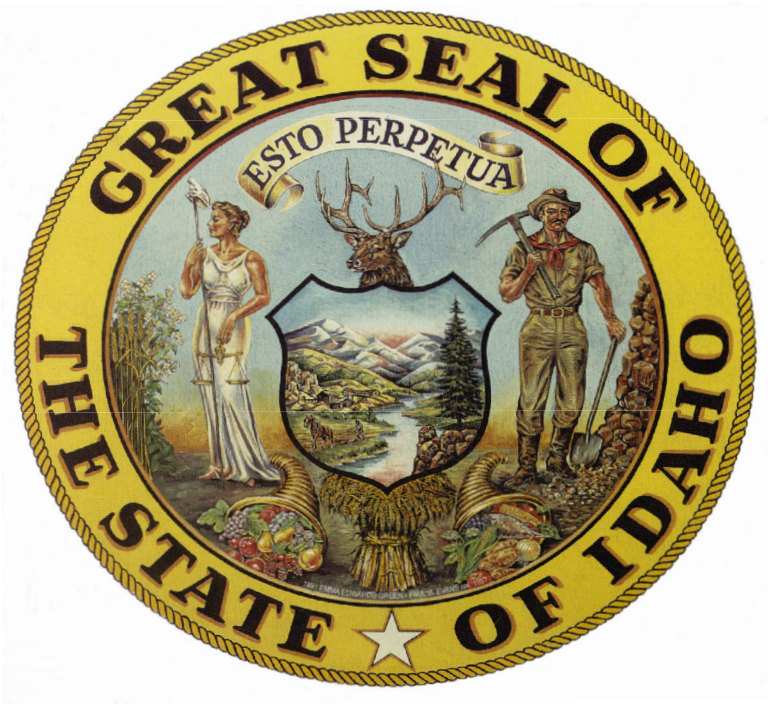
IDAHO ADMINISTRATIVE BULLETIN

June 4, 2025 – Vol. 25-6

Office of the Governor
Division of Financial Management
Office of the Administrative Rules Coordinator



The Idaho Administrative Bulletin is published monthly by the Office of the Administrative Rules Coordinator, Division of Financial Management, Office of the Governor, pursuant to Title 67, Chapter 52, Idaho Code.

Brad Little, Governor
Lori Wolff, Administrator, Division of Financial Management
Lauren Smyser, Regulatory & Legislative Affairs Chief
Bradley A. Hunt, Administrative Rules Coordinator
Logan P. Medel, Administrative Rules Specialist
Margaret Major, Desktop Publishing Specialist

IDAHO ADMINISTRATIVE BULLETIN

Table of Contents

June 4, 2025 – Vol. 25-6

PREFACE 5

IDAPA 08 – STATE BOARD OF EDUCATION

08.01.13 – Rules Governing the Opportunity Scholarship Program

Docket No. 08-0113-2501

Notice of Intent to Promulgate Rules – Negotiated Rulemaking 12

08.02.02 – Rules Governing Uniformity

Docket No. 08-0202-2501

Notice of Intent to Promulgate Rules – Negotiated Rulemaking 14

08.02.03 – Rules Governing Thoroughness

Docket No. 08-0203-2501

Notice of Intent to Promulgate Rules – Negotiated Rulemaking 16

Docket No. 08-0203-2502

Notice of Intent to Promulgate Rules – Negotiated Rulemaking 18

08.02.05 – Rules Governing Pay for Success Contracting

Docket No. 08-0205-2501

Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking 20

IDAPA 11 – IDAHO STATE POLICE

11.06.01 – Rules Governing Civil Asset Forfeiture Reporting

Docket No. 11-0601-2501

Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking 22

11.10.01 – Rules Governing Idaho Public Safety and Security Information System

Docket No. 11-1001-2501

Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking 24

11.10.02 – Rules Governing State Criminal History Records and Crime Information

Docket No. 11-1002-2501

Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking 26

11.10.03 – Rules Governing the Sex Offender Registry

Docket No. 11-1003-2501

Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking 28

IDAPA 13 – IDAHO FISH AND GAME COMMISSION

Establishing Seasons and Limits for Hunting, Fishing, and Trapping in Idaho

Docket No. 13-0000-2500P3

Notice of Adopted / Amended Proclamations for Calendar Year 2025 30

IDAPA 13 – IDAHO DEPARTMENT OF FISH AND GAME

13.01.04 – Rules Governing Licensing

Docket No. 13-0104-2501

Notice of Rulemaking – Adoption of Temporary Rule 31

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE
16.02.10 – Idaho Reportable Diseases
Docket No. 16-0210-2501 (ZBR Chapter Rewrite)
Notice of Rulemaking – Proposed Rule 35
16.02.27 – Idaho Radiation Control Rules
Docket No. 16-0227-2501 (ZBR Chapter Rewrite)
Notice of Rulemaking – Proposed Rule 88
16.03.21 – Developmental Disabilities Agencies (DDA)
Docket No. 16-0321-2501 (Chapter Rewrite)
Notice of Rulemaking – Proposed Rule 101
16.03.22 – Residential Assisted Living Facilities
Docket No. 16-0322-2501 (ZBR Chapter Rewrite)
Notice of Rulemaking – Proposed Rule 126
16.03.26 – Medicaid Plan Benefits
Docket No. 16-0326-2501 (New Chapter)
Notice of Rulemaking – Temporary and Proposed Rule 175
16.04.17 – Residential Habilitation Agencies
Docket No. 16-0417-2501 (ZBR Chapter Repeal)
Notice of Rulemaking – Proposed Rule 336
16.05.01 – Use and Disclosure of Department Records
Docket No. 16-0501-2501 (ZBR Chapter Rewrite)
Notice of Rulemaking – Proposed Rule 337

IDAPA 34 – SECRETARY OF STATE
34.03.01 – Rules Implementing the Sunshine Law
Docket No. 34-0301-2501
Notice of Rulemaking – Proposed Rule 352

IDAPA 45 – IDAHO HUMAN RIGHTS COMMISSION
45.01.01 – Rules of the Idaho Human Rights Commission
Docket No. 45-0101-2501
Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking 355

IDAPA 55 – DIVISION OF CAREER TECHNICAL EDUCATION
55.01.03 – Rules of Career Technical Centers
Docket No. 55-0103-2501
Notice of Intent to Promulgate Rules – Negotiated Rulemaking 357

IDAPA 62 – OFFICE OF ADMINISTRATIVE HEARINGS
62.01.01 – Idaho Rules of Administrative Procedure
Docket No. 62-0101-2501
Notice of Intent to Promulgate Rules – Negotiated Rulemaking 359

SECTIONS AFFECTED INDEX 362

LEGAL NOTICE – SUMMARY OF PROPOSED RULEMAKINGS 380

CUMULATIVE RULEMAKING INDEX OF IDAHO ADMINISTRATIVE RULES 382

SUBJECT INDEX 404

PREFACE

The Idaho Administrative Bulletin is an electronic-only, online monthly publication of the Office of the Administrative Rules Coordinator, Division of Financial Management, that is published pursuant to Section 67-5203, Idaho Code. The Bulletin is a compilation of all official rulemaking notices, official rule text, executive orders of the Governor, and all legislative documents affecting rules that are statutorily required to be published in the Bulletin. It may also include other rules-related documents an agency may want to make public through the Bulletin.

State agencies are required to provide public notice of all rulemaking actions and must invite public input. This is done through negotiated rulemaking procedures or after proposed rulemaking has been initiated. The public receives notice that an agency has initiated proposed rulemaking procedures through the Idaho Administrative Bulletin and a legal notice (Public Notice of Intent) that publishes in authorized newspapers throughout the state. The legal notice provides reasonable opportunity for the public to participate when a proposed rule publishes in the Bulletin. Interested parties may submit written comments to the agency or request public hearings of the agency, if none have been scheduled. Such submissions or requests must be presented to the agency within the time and manner specified in the individual "Notice of Rulemaking - Proposed Rule" for each proposed rule that is published in the Bulletin.

Once the comment period closes, the agency considers fully all comments and information submitted regarding the proposed rule. Changes may be made to the proposed rule at this stage of the rulemaking, but changes must be based on comments received and must be a "logical outgrowth" of the proposed rule. The agency may now adopt and publish the pending rule. A pending rule is "pending" legislative review for final approval. The pending rule is the agency's final version of the rulemaking that will be forwarded to the legislature for review and final approval. Comment periods and public hearings are not provided for when the agency adopts a temporary or pending rule.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is identified by the calendar year and issue number. For example, Bulletin **22-1** refers to the first Bulletin issued in calendar year **2022**; Bulletin **24-1** refers to the first Bulletin issued in calendar year **2024**. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. **22-1** refers to January 2022; Volume No. **24-2** refers to February 2024; and so forth. Example: The Bulletin published in January 2022 is cited as Volume **22-1**. The December 2022 Bulletin is cited as Volume **22-12**.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

The **Idaho Administrative Code** is an electronic-only, online compilation of all final and enforceable administrative rules of the state of Idaho that are of full force and effect. Any temporary rule that is adopted by an agency and is of force and effect is codified into the Administrative Code upon Bulletin publication. All pending rules that have been approved by the legislature during the legislative session as final rules and any temporary rules that are extended supplement the Administrative Code. These rules are codified into the Administrative Code upon becoming effective. Because proposed and pending rules are not enforceable, they are published in the Administrative Bulletin only and cannot be codified into the Administrative Code until approved as final.

To determine if a particular rule remains in effect or whether any amendments have been made to the rule, refer to the Cumulative Rulemaking Index. Link to it on the Administrative Rules homepage at adminrules.idaho.gov.

THE DIFFERENT RULES PUBLISHED IN THE ADMINISTRATIVE BULLETIN

Idaho's administrative rulemaking process, governed by the Idaho Administrative Procedure Act, Title 67, Chapter 52, Idaho Code, comprises distinct rulemaking actions: negotiated, proposed, temporary, pending, and final rulemaking. Not all rulemakings incorporate or require all of these actions. For a rule to become final, at a minimum, a rulemaking includes proposed, pending, and final rulemaking. Some rules may be adopted as temporary rules when they meet the required statutory criteria. Agencies must, when feasible, engage in negotiated rulemaking at the beginning of the process to facilitate consensus building. In some cases, the process may begin with proposed rulemaking and end with the final rulemaking. The following is a brief explanation of each type of rule.

1. NEGOTIATED RULEMAKING

Negotiated rulemaking is a process in which all interested persons and the agency seek consensus on the content of a rule through dialogue. Agencies are required to conduct negotiated rulemaking whenever it is feasible to do so. The agency files a "Notice of Intent to Promulgate – Negotiated Rulemaking" for publication in the Administrative Bulletin inviting interested persons to contact the agency if interested in discussing the agency's intentions regarding the rule changes. This process is intended to result in the formulation of a proposed rule and the initiation of regular rulemaking procedures. One result, however, may also be that regular (proposed) rulemaking is not initiated and no further action is taken by the agency.

2. PROPOSED RULEMAKING

A proposed rulemaking is an action by an agency wherein 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 Rulemaking – Proposed Rule" in the Bulletin. This notice must include very specific information regarding the rulemaking including all relevant state or federal statutory authority occasioning the rulemaking, a non-technical description of the changes being made, any associated costs, guidance on how to participate through submission of written comments and requests for public hearings, and the text of the proposed rule in legislative format.

3. PENDING RULEMAKING

A pending rule is a rule that has been adopted by an agency under regular rulemaking procedures 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 Rulemaking – Pending Rule." This includes a statement giving the reasons for adopting the rule, a statement regarding when the rule becomes effective, a description of how it differs from the proposed rule, and identification of any fees being imposed or changed.

Agencies are required to republish the text of the pending 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 change 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.

4. FINAL RULEMAKING

A final rule is a rule that has been adopted by an agency under the regular rulemaking procedures, has been approved by the legislature, and is of full force and effect.

5. TEMPORARY RULEMAKING

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

a) protection of the public health, safety, or welfare; or
b) compliance with deadlines in amendments to governing law or federal programs; or
c) reducing a regulatory burden that would otherwise impact individuals or businesses.

If a rulemaking meets one or more of these criteria, and with the Governor's approval, the agency may adopt and make a temporary rule effective prior to receiving legislative authorization and without allowing for any public input. The law allows an agency to make a temporary rule immediately effective upon adoption. A temporary rule expires at the conclusion of the next succeeding regular legislative session unless the rule is extended by concurrent resolution, is replaced by a final rule, or expires under its own terms.

Agencies must concurrently promulgate a temporary rule and a proposed rule when the text of the two rulemakings is the same, unless the temporary rule will expire before a proposed rule could become final.

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 schematic. 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 sections 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 that are further subdivided into subsections. An example IDAPA number is as follows:

IDAPA 38.05.01.041.02.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.

"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"

"041." refers to Major Section **041**, "Acquisition Procedures"

"02." refers to Subsection 041.**02**.

"**c.**" refers to Subsection 041.02.**c**.

"ii." refers to Subsection 041.02.c.**ii**.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. Each rulemaking that is filed with the Coordinator is assigned a "DOCKET NUMBER." The docket number is a series of numbers separated by a hyphen "-", (**38-0501-2201**). Rulemaking dockets are published sequentially by IDAPA number (the two-digit agency code) in the Bulletin. The following example is a breakdown of a typical rule docket number:

"DOCKET NO. 38-0501-2201"

"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**).

"2201" denotes the year and sequential order of the docket being published; in this case the numbers refer to the first rulemaking action published in **calendar year 2022**. A subsequent rulemaking on this same rule chapter in calendar year 2022 would be designated as "**2202**". The docket number in this scenario would be 38-0501-**2202**.

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)

RULEMAKING DEADLINES CY 2025

BULLETIN MONTH / VOL.	FEB 25-2	MAR 25-3	APR 25-4	MAY 25-5	JUN 25-6	JUL 25-7	AUG 25-8	SEPT 25-9	OCT 25-10	NOV 25-11	DEC 25-12	JAN '26 26-1
ARRF DUE	Dec 20	Jan 24	Feb 21	Mar 21	April 18	May 23	June 20	July 18	Aug 15	Sept 19	Oct 24	Nov 21
AGENCY FILING DUE	Jan 3	Feb 7	Mar 7	April 4	May 2	June 6	July 3	Aug 1	*Aug 29	Oct 3	Nov 7	**Dec 5
BULLETIN PUBLISHED	Feb 5	Mar 5	April 2	May 7	June 4	July 2	Aug 6	Sept 3	Oct 1	Nov 5	Dec 3	Jan 7
21-DAY COMMENT ENDS	Feb 26	Mar 5	April 23	May 28	June 25	July 23	Aug 27	Sept 24	Oct 22	Nov 26	Dec 24	Jan 28

August 29, 2025: Last day to submit a Proposed Rule for the upcoming Legislature

****December 5, 2025: Last day to submit a Pending Rule for the upcoming Legislature***

RULEMAKING DEADLINES CY 2026

BULLETIN MONTH / VOL.	FEB 26-2	MAR 26-3	APR 26-4	MAY 26-5	JUN 26-6	JUL 26-7	AUG 26-8	SEPT 26-9	OCT 26-10	NOV 26-11	DEC 26-12	JAN '27 27-1
ARRF DUE	Dec 26	Jan 23	Feb 20	March 20	April 17	May 15	June 19	July 17	Aug 14	Sept 18	Oct 16	Nov 20
AGENCY FILING DUE	Jan 9	Feb 6	Mar 6	April 3	May 1	May 29	July 3	July 31	*Aug 28	Oct 2	Oct 30	**Dec 4
BULLETIN PUBLISHED	Feb 4	Mar 4	April 1	May 6	June 3	July 1	Aug 5	Sept 2	Oct 7	Nov 4	Dec 2	Jan 6
21-DAY COMMENT ENDS	Feb 25	Mar 25	April 22	May 27	June 24	July 22	Aug 26	Sept 23	Oct 28	Nov 25	Dec 23	Jan 27

August 28, 2026: Last day to submit a Proposed Rule for the upcoming Legislature

****December 4, 2026: Last day to submit a Pending Rule for the upcoming Legislature***

Access to DFM's Administrative Rules Request Form (ARRF)

Access the Idaho Rule Writer's Manual

ALPHABETICAL INDEX OF STATE AGENCIES AND CORRESPONDING IDAPA NUMBERS

IDAPA 38	**Administration**, Department of
IDAPA 62	**Administrative Hearings**, Office of
IDAPA 02	**Agriculture**, Idaho State Department of Idaho Honey Commission (02.06.16) Idaho Hop Grower's Commission (02.07) Idaho Sheep and Goat Health Board (02.08)
IDAPA 40	**Arts**, Idaho Commission on the
IDAPA 04	**Attorney General,** Office of the
IDAPA 53	**Barley Commission**, Idaho
IDAPA 51	**Beef Council**, Idaho
IDAPA 55	**Career Technical Education**, Division of
IDAPA 28	**Commerce**, Idaho Department of
IDAPA 06	**Correction**, Idaho Department of
IDAPA 63	**Domestic Violence and Victim Assistance**, Idaho Council on
IDAPA 08	**Education**, State Board of and State Department of
IDAPA 32	**Endowment Fund Investment Board**
IDAPA 58	**Environmental Quality**, Department of
IDAPA 12	**Finance**, Idaho Department of
IDAPA 13	**Fish and Game**, Idaho Department of
IDAPA 15	**Governor**, Office of the Idaho Commission on Aging (15.01) Idaho Commission for the Blind and Visually Impaired (15.02) Idaho Forest Products Commission (15.03) Division of Human Resources and Personnel Commission (15.04) Idaho Military Division (Division of Homeland Security) (15.06) Idaho State Liquor Division (15.10)
IDAPA 48	**Grape Growers and Wine Producers Commission,** Idaho
IDAPA 16	**Health and Welfare**, Department of
IDAPA 45	**Human Rights Commission**
IDAPA 17	**Industrial Commission,** Idaho
IDAPA 18	**Insurance**, Idaho Department of
IDAPA 05	**Juvenile Corrections**, Department of

ALPHABETICAL INDEX OF STATE AGENCIES AND CORRESPONDING IDAPA NUMBERS

IDAPA 09	**Labor**, Idaho Department of
IDAPA 20	**Lands**, Idaho Department of
IDAPA 52	**Lottery Commission**, Idaho State
IDAPA 24	**Occupational and Professional Licenses**, Division of Accountancy, Board of (24.30) Acupuncture, Board of (24.17) Architects and Landscape Architects, Board of (24.01) Athletic Commission, State (24.02) Barber and Cosmetology Services Licensing Board (24.28) Building Safety, Division of (24.39) Chiropractic Physicians, Board of (24.03) Contractors Board, Idaho State (24.21) Counselors and Marriage and Family Therapists, Licensing Board of Professional (24.15) Dentistry, State Board of (24.31) Denturitry, State Board of (24.16) Drinking Water and Wastewater Professionals, Board of (24.05) Driving Businesses Licensure Board, Idaho (24.25) Engineers and Land Surveyors, Board of Licensure of Professional (24.32) Genetic Counselors Licensing Board (24.24) Geologists, Board of Registration for Professional (24.04) Liquefied Petroleum Gas Safety Board (24.22) Massage Therapy, Board of (24.27) Medicine, Board of (24.33) Midwifery, Board of (24.26) Morticians, Board of (24.08) Naturopathic Health Care, Board of (24.40) Nursing, Board of (24.34) Nursing Home Administrators, Board of Examiners of (24.09) Occupational Therapy Licensure Board (24.06) Optometry, Board of (24.10) Outfitters and Guides Licensing Board (24.35) Pharmacy, Board of (24.36) Physical Therapy Licensure Board (24.13) Podiatry, Board of (24.11) Psychologist Examiners, Board of (24.12) Real Estate Appraiser Board (24.18) Real Estate Commission (24.37) Residential Care Facility Administrators, Board of Examiners of (24.19) Shorthand Reporters Board, Idaho Certified (24.29) Social Work Examiners, Board of (24.14) Speech, Hearing and Communication Services Licensure Board (24.23) Veterinary Medicine, State Board of (24.38)
IDAPA 43	**Oilseed Commission**, Idaho
IDAPA 50	**Pardons and Parole**, Commission of
IDAPA 26	**Parks and Recreation**, Idaho Department of

ALPHABETICAL INDEX OF STATE AGENCIES AND CORRESPONDING IDAPA NUMBERS

IDAPA 11	**Police,** Idaho State Alcohol Beverage Control (11.05) Brand Board (11.02) Commercial Vehicle Safety (11.13) Forensic Laboratory (11.03) Motor Vehicles (11.07) Peace Officer Standards and Training Council (11.11) Public Safety and Security Information (11.10) Racing Commission (11.04)
IDAPA 29	**Potato Commission**, Idaho
IDAPA 59	**Public Employee Retirement System of Idaho (PERSI)**
IDAPA 31	**Public Utilities Commission**
IDAPA 34	**Secretary of State**, Office of the
IDAPA 57	**Sexual Offender Management Board**
IDAPA 60	**Soil and Water Conservation Commission**, Idaho State
IDAPA 36	**Tax Appeals**, Board of
IDAPA 35	**Tax Commission**, State
IDAPA 39	**Transportation Department,** Idaho
IDAPA 21	**Veterans Services**, Division of
IDAPA 47	**Vocational Rehabilitation**, Division of
IDAPA 37	**Water Resources**, Department of
IDAPA 42	**Wheat Commission**, Idaho

IDAPA 08 – STATE BOARD OF EDUCATION

08.01.13 – RULES GOVERNING THE OPPORTUNITY SCHOLARSHIP PROGRAM

DOCKET NO. 08-0113-2501

NOTICE OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Article IX, Section 2, Idaho Constitution and under Sections 33-105, 33-4303, and 33-4304, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Wednesday, June 11, 2025 **&** **Wednesday, June 25, 2025** **9:00 a.m. MT**
In Person: **650 W State St. Boise, ID 83702** **3rd Floor, OSBE Conference Room** **Virtual:** **Zoom link: https://us02web.zoom.us/j/88061187540** **Meeting ID: 880 6118 7540**

The meeting site(s) will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (1) day prior to the meeting to the agency address below.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

The proposed change will edit subsection 300.02.b by removing a portion of the section.

The change permits private Idaho postsecondary institutions to use their actual cost of attendance when determining awards for Idaho Opportunity Scholarship recipients rather than public institution costs. Currently, private institutions are required to base awards on the average cost of attendance at public institutions. The amount of an opportunity scholarship awarded to an individual student shall not exceed the actual cost of tuition and fees at the institution the student attends. Therefore, because many students at private institutions receive substantial institutional aid, this often results in students being ineligible for funding from the Idaho Opportunity Scholarship program. Given the relatively low student enrollment at these institutions, allowing full award amounts is unlikely to significantly impact the number of recipients at other institutions.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text contact Nicholas Wagner at rules@edu.idaho.gov or (208)-488-7586.

Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho State Board of Education website at the following web address: https://boardofed.idaho.gov/board-policies-rules/board-rules/education-rules/.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 2, 2025.

DATED this 3rd day of May, 2025.

Nicholas Wagner
Administrative Rules Coordinator, Idaho State Board of Education
650 W State St., PO Box 83720, Boise, ID 83720-0037
Phone: (208)488-7586; Fax: (208)334-2632

IDAPA 08 – STATE BOARD OF EDUCATION

08.02.02 – RULES GOVERNING UNIFORMITY

DOCKET NO. 08-0202-2501

NOTICE OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Article IX, Section 2 of the Idaho Constitution and under Sections 33-105, 33-107, 33-116, 33-1612, 33-2203, and 33-2205, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Thursday, June 12, 2025
10:00 a.m. MT

In Person:
650 W State St. Boise, ID 83702
3rd Floor, Clearwater Conference Room

Join by Zoom Link:
https://us02web.zoom.us/j/85472302130
Meeting ID: 854 7230 2130

The meeting site(s) will be accessible to persons with disabilities, if needed. Requests for accommodation must be made at least one (1) day prior to the meeting to the agency address below.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

The proposed changes to subsection 08.02.02.076, Code of Ethics for Idaho Professional Educators aim to reduce unethical interactions between educators and students by limiting educator/student communications to district approved devices and platforms that can be viewed and monitored by district staff. Communication tends to be more professional when personal accounts are not used, and educators are aware that communication with students is not private. Additionally, clarifies that it is unethical to use a district device or network to engage in any sexually explicit activity, not just accessing pornography. Finally, proposed language provides that co-mingling public funds with any person account is unethical, not just personal bank accounts. The final change regarding the code of ethics section is to clarify that professionalism is not limited to conduct with colleagues but encompasses all professional conduct.

Furthermore, Section 33-2205, Idaho Code, requires individuals seeking a CTE instructional certificate who hold a bachelors degree to have a minimum of 2,000 hours of industry experience, the rule states 1,000 hours, the change would reference back to the statutory requirement rather than having a set number, the other changes will remove confusion allowing for an easier process for awarding CTE instructional certificates. The proposed rule will also remove a conflict between the rule and Section 33-2205, Idaho code. It will replace the conflict with a reference to the

statute and add clarifying language around CTE certification. The current requirement for CTE Certification for individuals coming from a degree-based program does not align with the statutory requirement. The changes would align the rule with statute and provide additional clarification in areas specific to the limited occupational specialist interim certificate and non-CTE interim certificates. Additionally, changes would provide clarification/streamlining the process for staff holding non-CTE certification to also earn a CTE certificate.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text contact Nicholas Wagner at rules@edu.idaho.gov or (208)-488-7586.

Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho State Board of Education website at the following web address: https://boardofed.idaho.gov/board-policies-rules/board-rules/education-rules/.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 2, 2025.

DATED this 3rd day of May, 2025.

Nicholas Wagner
Administrative Rules Coordinator, Idaho State Board of Education
650 W State St., PO Box 83720, Boise, ID 83720-0037
Phone: (208)488-7586; Fax: (208)334-2632

IDAPA 08 – STATE BOARD OF EDUCATION

08.02.03 – RULES GOVERNING THOROUGHNESS

DOCKET NO. 08-0203-2501

NOTICE OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Article IX, Section 2 of the Idaho Constitution and under sections 33-105, 33-116, 33-118, and 33-1612, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Tuesday, June 24, 2025
10:00 a.m. MT

In Person:
650 W State St. Boise, ID 83702
2nd Floor, Lewis & Clark Conference Room

Join by Zoom Link:
https://idahosde.zoom.us/j/99175442016
Meeting ID: 991 7544 2016

The meeting site(s) will be accessible to persons with disabilities, if needed. Requests for accommodation must be made at least one (1) day prior to the meeting to the agency address below.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

The proposed change will edit the incorporated by reference Special Education Manual document, subsection 004.04. The incorporated by reference document was revised and approved in the 2024-25, rulemaking cycle. The section of the manual updated was the Specific Learning Disability (SLD) section, following an inquiry from the U.S. Department of Education's Office of Special Education Programs (OSEP) in 2023. Concurrently, the Idaho Department of Education underwent a Differentiated Monitoring and Support 2.0 (DMS 2.0) review by OSEP, which identified additional areas of concern. However, due to timing and procedural requirements for public input under Individuals with Disabilities Education Act (IDEA), as well as rulemaking timelines set by the Department of Financial Management (DFM) and the Office of the State Board of Education (OSBE), these concerns could not be addressed in the same revision as the SLD update that was completed in the 2024-25 rulemaking cycle.

2025-26 manual updates and clarifications include: specific learning disability (SLD) eligibility requirements; guidance related to charter school, private school, and home-school students; and guidance related to graduation requirements and discipline.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text contact Nicholas Wagner at rules@edu.idaho.gov or (208)-488-7586.

Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho State Board of Education website at the following web address: https://boardofed.idaho.gov/board-policies-rules/board-rules/education-rules/.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 2, 2025.

DATED this 3rd day of May, 2025.

Nicholas Wagner
Administrative Rules Coordinator, Idaho State Board of Education
650 W State St., PO Box 83720, Boise, ID 83720-0037
Phone: (208)488-7586; Fax: (208)334-2632

IDAPA 08 – STATE BOARD OF EDUCATION

08.02.03 – RULES GOVERNING THOROUGHNESS

DOCKET NO. 08-0203-2502

NOTICE OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Article IX, Section 2 of the Idaho Constitution and under sections 33-105, 33-116, 33-118, and 33-1612, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Tuesday, June 24, 2025
10:00 a.m. MT

In Person:
650 W State St. Boise, ID 83702
2nd Floor, Lewis & Clark Conference Room

Join by Zoom Link:
https://idahosde.zoom.us/j/99175442016
Meeting ID: 991 7544 2016

The meeting site(s) will be accessible to persons with disabilities, if needed. Requests for accommodation must be made at least one (1) day prior to the meeting to the agency address below.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

The proposed rule changes to the Social Studies K-12 content standards incorporated by reference document outlined in subsection 004.01.g, are currently being reviewed. The Social Studies standards were reviewed during the 2023-2024 school year and submitted to the Idaho legislature for final approval during the 2025 session. The legislature rejected portions of the revised Social Studies standards and would like the standards reviewed again. Based on the 2025 legislative action, additional revisions to the Social Studies standards will be facilitated by the Idaho Department of Education for legislative consideration during the 2026 session.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text contact Nicholas Wagner at rules@edu.idaho.gov or (208)-488-7586.

Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho State Board of Education website at the following web address: https://boardofed.idaho.gov/board-policies-rules/board-rules/education-rules/.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 2, 2025.

DATED this 3rd day of May, 2025.

Nicholas Wagner
Administrative Rules Coordinator, Idaho State Board of Education
650 W State St., PO Box 83720, Boise, ID 83720-0037
Phone: (208)488-7586; Fax: (208)334-2632

IDAPA 08 – STATE BOARD OF EDUCATION

08.02.05 – RULES GOVERNING PAY FOR SUCCESS CONTRACTING

DOCKET NO. 08-0205-2501

NOTICE OF INTENT TO PROMULGATE RULES – ZERO-BASED REGULATION (ZBR) NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to sections 33-125b, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Wednesday, June 11, 2025
&
Wednesday, June 25, 2025
11:00 a.m. MT

In Person:
650 W State St. Boise, ID 83702
3rd Floor, OSBE Conference Room

Virtual:
Zoom link: https://us02web.zoom.us/j/89878461823
Meeting ID: 898 7846 1823

The meeting site(s) will be accessible to persons with disabilities, if needed. Requests for accommodation must be made at least one (1) day prior to the meeting to the agency address below.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

The rule was promulgated and structured around statute 33-125B, Idaho code. 33-125B and the rule has not been utilized in the State Department of Education in recent years or possibly ever. Additionally, IDAPA 08.02.05 is scheduled for the review in reference to the ZBR review process brought forth by Executive Order 2020-21. The process requires full chapter evaluation of how it can be improved, simplified, and streamlined. Any provisions duplicative of statutory language will also be removed. For this reason, the action of this rule is to repeal the rule in its entirety.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text contact Nicholas Wagner at rules@edu.idaho.gov or (208)-488-7586.

Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho State Board of Education website at the following web address: https://boardofed.idaho.gov/board-policies-rules/board-rules/education-rules/.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 2, 2025.

DATED this 3rd day of May, 2025.

Nicholas Wagner
Administrative Rules Coordinator, Idaho State Board of Education
650 W State St., PO Box 83720
Boise, ID 83720-0037
Phone: (208)488-7586; Fax: (208)334-2632

IDAPA 11 – IDAHO STATE POLICE

11.06.01 – RULES GOVERNING CIVIL ASSET FORFEITURE REPORTING

DOCKET NO. 11-0601-2501

NOTICE OF INTENT TO PROMULGATE RULES – ZERO-BASED REGULATION (ZBR) NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Section(s) 67-2901 and 37-2744, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Tuesday, June 10, 2025
10:30 a.m. -11:30 a.m. MT

In Person:
Idaho State Police Headquarters
700 S Stratford Dr.
Meridian, ID 83642

Virtual:
Join the meeting now
Meeting ID: 271 733 210 207
Passcode: ei7Ps2Sw

Dial in by Phone:
tel:+18722156990,,601024227
Phone Conference ID: 601 024 227#

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

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do any of the following:

- Attend the negotiated rulemaking meeting and participate in the rulemaking process,
- Provide oral presentations with advance notice in writing for the record by emailing michael.kish@isp.idaho.gov,
- Submit written recommendations and comments to the email address above.

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

Under Executive Order 2020-01 Zero-Based Regulation, the Idaho State Police is striving to prevent the accumulation of costly or outdated regulations and reduce the regulatory burden on Idaho citizens and businesses.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text (if available), contact Captain Mike Kish, (208) 884-7207, Michael.kish@isp.idaho.gov.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 1, 2025.

DATED this 21st day of April, 2025.

Lt Colonel Russ Wheatley, Chief of Staff
Idaho State Police
700 S Stratford Drive
Meridian ID 83642
(208) 884-7004
Russ.wheatley@isp.idaho.gov

IDAPA 11 – IDAHO STATE POLICE
IDAHO PUBLIC SAFETY AND SECURITY INFORMATION SYSTEM

11.10.01 – RULES GOVERNING IDAHO PUBLIC SAFETY AND SECURITY INFORMATION SYSTEM

DOCKET NO. 11-1001-2501

NOTICE OF INTENT TO PROMULGATE RULES – ZERO-BASED REGULATION (ZBR) NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Section(s) 19-5201, 19-5202, 19-5203, and 19-5204, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Monday, June 9, 2025
10:30 a.m. -11:30 a.m. MT

In Person:
Idaho State Police Headquarters
Cafeteria Conference Room
700 S Stratford Dr.
Meridian, ID 83642

Virtual:
Join the meeting now
Meeting ID: 271 733 210 207
Passcode: ei7Ps2Sw

Dial in by Phone:
tel:+18722156990,,939948368
Phone Conference ID: 939948368#

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

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Those interested in participating in the negotiated rulemaking process are encouraged to attend scheduled meetings in person, via Teams at the link provided, or by conference call using the number listed in this notice. Those interested may also submit written comments within the comment period by sending them to the address below.

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

ISP initiated this rulemaking in compliance with Executive Order No 2020-01 Zero-Based Regulation issued by Governor Little. Pursuant to the order, ISP performed a comprehensive review of the chapter to reduce the regulatory burden and increase clarity.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text (if available), contact Bureau Chief Leila McNeill at 208-884-7136, email – Leila.McNeill@isp.idaho.gov.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25, 2025.

DATED this 30th day of April, 2025.

Lieutenant Colonel Russ Wheatley, Chief of Staff
Idaho State Police
700 S Stratford Drive
Meridian ID 83642
(208) 884-7004
Russ.wheatley@isp.idaho.gov

IDAPA 11 – IDAHO STATE POLICE

11.10.02 – RULES GOVERNING STATE CRIMINAL HISTORY RECORDS AND CRIME INFORMATION

DOCKET NO. 11-1002-2501

NOTICE OF INTENT TO PROMULGATE RULES – ZERO-BASED REGULATION (ZBR) NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Section(s) 67-3001, 67-3003, 67-3004, 67-3007, and 67-3010, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Monday, June 9, 2025
1:00 p.m. -3:00 p.m. MT

In Person:
Idaho State Police Headquarters
Cafeteria Conference Room
700 S Stratford Dr.
Meridian, ID 83642

Virtual:
Join the meeting now
Meeting ID: 271 733 210 207
Passcode: ei7Ps2Sw

Dial in by Phone:
tel:+18722156990,,939948368#
Phone Conference ID: 939948368#

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

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Those interested in participating in the negotiated rulemaking process are encouraged to attend scheduled meetings in person, via Teams at the link provided, or by conference call using the number listed in this notice. Those interested may also submit written comments within the comment period by sending them to the address below.

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

ISP initiated this rulemaking in compliance with Executive Order No 2020-01 Zero-Based Regulation issued by Governor Little. Pursuant to the order, ISP performed a comprehensive review of the chapter to reduce the regulatory burden and increase clarity.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text (if available), contact Bureau Chief Leila McNeill at 208-884-7136, email – Leila.McNeill@isp.idaho.gov.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25, 2025.

DATED this 2nd day of May, 2025.

Lieutenant Colonel Russ Wheatley, Chief of Staff
Idaho State Police
700 S Stratford Drive
Meridian ID 83642
(208) 884-7004
Russ.wheatley@isp.idaho.gov

IDAPA 11 – IDAHO STATE POLICE

11.10.03 – RULES GOVERNING THE SEX OFFENDER REGISTRY

DOCKET NO. 11-1003-2501

NOTICE OF INTENT TO PROMULGATE RULES – ZERO-BASED REGULATION (ZBR) NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Section(s) 18-8301-18-8331, Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Monday, June 9, 2025
1:00 p.m.-3:00 p.m. MT

In Person:
Idaho State Police Headquarters
Cafeteria Conference Room
700 S Stratford Dr.
Meridian, ID 83642

Virtual:
Join the meeting now
Meeting ID: 271 733 210 207
Passcode: ei7Ps2Sw

Dial in by Phone:
tel:+18722156990,,939948368#
Phone Conference ID: 939948368#

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

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Those interested in participating in the negotiated rulemaking process are encouraged to attend scheduled meetings in person, via Teams at the link provided, or by conference call using the number listed in this notice. Those interested may also submit written comments within the comment period by sending them to the address below.

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

ISP initiated this rulemaking in compliance with Executive Order No 2020-01 Zero-Based Regulation issued by Governor Little. Pursuant to the order, ISP performed a comprehensive review of the chapter to reduce the regulatory burden and increase clarity.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text (if available), contact Bureau Chief Leila McNeill at 208-884-7136, email – Leila.McNeill@isp.idaho.gov.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25, 2025.

DATED this 30th day of April, 2025.

Lieutenant Colonel Russ Wheatley, Chief of Staff
Idaho State Police
700 S Stratford Drive
Meridian ID 83642
(208) 884-7004
Russ.wheatley@isp.idaho.gov

IDAPA 13 – IDAHO FISH AND GAME COMMISSION

ESTABLISHING SEASONS AND LIMITS FOR HUNTING, FISHING, AND TRAPPING IN IDAHO

DOCKET NO. 13-0000-2500P3

NOTICE OF ADOPTED / AMENDED PROCLAMATIONS FOR CALENDAR YEAR 2025

AUTHORITY: As authorized by Section 36-104, Idaho Code, and in compliance with Sections 36-105(3), Idaho Code, the Commission adopts proclamations establishing seasons and limits for hunting, fishing, and trapping in Idaho.

AVAILABILITY OF OFFICIAL PROCLAMATIONS: Hunters, anglers, and trappers are advised to consult the text of the Commission's official proclamation before hunting, fishing, or trapping. All proclamations are available on-line at https://idfg.idaho.gov/rules, with print versions available at Idaho Department of Fish and Game offices and license vendors.

DESCRIPTIVE SUMMARY AND PUBLIC MEETING SCHEDULE: The Commission meeting schedule and meeting agendas are available on-line at https://idfg.idaho.gov/about/commission/schedule, with opportunities for public comment generally scheduled at its January, March, May, July, and November meetings.

Information for Commission proclamations for calendar year 2025 was initially published in the Idaho Administrative Bulletin, February 5, 2025, Bulletin Volume 25-2, pages 10-11.

At a May 13, 2025, special meeting the Commission took the following proclamation action:

1. Amended its proclamation for 2025 spring Chinook Salmon fishing, establishing seasons and limits for Chinook Salmon in the Clearwater River Basin.

At May 22, 2025, regular meeting the Commission took the following proclamation actions:

1. Amended its proclamation for the 2025-2027 fishing seasons, to adopt the spearfishing seasons and limits, to take effect July 1, 2025.

2. Amended its proclamation for 2025 spring Chinook Salmon fishing, establishing seasons and limits for Chinook Salmon in the Clearwater River Basin.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the proclamations, contact Owen Moroney at (208) 334-3715.

IDAPA 13 – IDAHO DEPARTMENT OF FISH AND GAME

13.01.04 – RULES GOVERNING LICENSING

DOCKET NO. 13-0104-2501

NOTICE OF RULEMAKING – ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is May 22, 2025.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section(s) 36-104, 36-104a, and 36-105, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule:

This temporary rule addresses a recommendation made by a Department-convened Nonresident Tag Issuance Advisory Group to adopt a draw framework for nonresident elk and deer tags in lieu of the existing over-the-counter non-resident tag framework. The intent is to address concerns around disorderly issuance of nonresident tags due to the nature of a first-come, first-served sale of this magnitude and the burden on the licensing system.

This rulemaking adds language establishing definitions, draw eligibility stipulations, deadlines, and application and refund criteria around a nonresident tag issuance draw system. Additionally, it consolidates two tag set-asides (the 14,000 total deer tags and the 1,500 white-tail specific tags) for systematic simplification and eliminates place in quota designation for nonresidents, which is currently not an option for residents. Outfitter designation remains unchanged.

Proposed rulemaking is being conducted under Docket No. 13-0104-2401, (Zero-Based Regulation (ZBR) Rulemaking), previously published in Bulletin Vol. 24-5, and Docket No. 13-0108-2401 (ZBR Rulemaking) as previously published in Bulletin Vol. 24-5 p. 188.

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

This temporary rule adoption protects public health, safety, or welfare relative to the orderly issuance of nonresident tags and prompt assessment of fiscal consequences, if any, to the Department's management of wildlife, support of hunting opportunities for residents, and Idaho business communities that rely on hunting-based recreation. Issuance of a temporary rule reduces the regulatory burden of the sale to individual nonresident applicants in 2026 by providing fewer restrictions than other controlled hunt draw frameworks, while evaluating tag sales in conjunction with final rulemaking or recommended legislation in the 2026 session.

FEE SUMMARY: There is no fee associated with the change brought by this rulemaking. A license will be required to apply for this type of hunt, consistent with the requirement for other controlled hunt structures.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Amber Worthington (208) 334-3771.

DATED this 23rd day of May, 2025.

Amber Worthington
Deputy Director
Idaho Department of Fish and Game
600 S. Walnut Street
P.O. Box 25
Boise, ID 83707
(208) 334-3771

THE FOLLOWING IS THE TEXT OF THE TEMPORARY RULE FOR DOCKET NO. 13-0104-2501
(Only Those Sections With Amendments Are Shown.)

13.01.04 – RULES GOVERNING LICENSING

508. – 5498. (RESERVED)

549. 2026 NR DRAW HUNTS FOR ELK AND DEER.
Notwithstanding other rules set forth in IDAPA 13.01, the following rules will apply to NR Draw Hunts for elk and deer in year 2026. (5-22-25)T

01. Definitions. The following definitions apply to this section. (5-22-25)T

a. Capped Hunt. Hunt framework in which deer or elk tags available to residents and nonresidents are limited by game management zone or unit. Capped hunt tags for year 2026 will be available to residents over the counter and available to nonresidents via NR draw hunts. (5-22-25)T

b. Controlled Hunt. Hunt framework in which tags are issued via drawing by lot by game management zone, unit, or other hunt area; landowner appreciation or outfitter allocation hunts established in conjunction with a controlled hunt; and landowner permission and emergency hunts established with requirements for tag issuance at Department offices. (5-22-25)T

c. Leftover Tag. A tag that is unsold or returned without use. (5-22-25)T

d. NR DAV Draw Hunt. Controlled hunt framework specific to drawing of reduced fee deer and elk tags for eligible nonresident disabled veterans. (5-22-25)T

e. NR Draw Hunt. Controlled hunt framework in which tags are available to residents over the counter but are issued by drawing by lot to nonresidents. These may include capped hunts and NRL hunts. (5-22-25)T

f. NRL Hunt. Hunt framework in which nonresident tags are limited but tags are available to residents over the counter without limit. NRL hunt tags for year 2026 will be NR draw hunts. (5-22-25)T

g. Over the Counter (First come, First Served). The sale of tags on a first-come, first-served basis on-line, at Department Offices and other vendor locations, without a drawing by lot. (5-22-25)T

02. Application Eligibility. (5-22-25)T

a. To apply for an NR draw hunt or an NR DAV draw hunt, a person must possess an Idaho hunting license or Idaho hunting passport valid for taking big game animals in year 2026. (5-22-25)T

b. Holders of lifetime license certificates are eligible to buy tags during the general hunt tag sale for residents, and they are not eligible to apply for NR draw hunts or NR DAV hunts. (5-22-25)T

c. Holders of nonresident junior mentored licenses are eligible to apply for NR draw hunts that are capped hunts. They are not subject to nonresident tag limits for NRL hunts, and are eligible to buy NRL hunt tags over the counter. (5-22-25)T

03. Eligibility for Multiple Hunt Applications and Tag Limits. (5-22-25)T

a. A person may only submit one (1) application each for deer or elk in NR draw hunts. An individual eligible for both NR DAV draw hunts and NR draw hunts may submit an application for each hunt type. (5-22-25)T

b. An individual who is successful in an NR DAV draw hunt or in the first application period of an NR draw hunt is not eligible to apply in the second application period for NR draw hunts. An application for an NR draw hunt or a DAV Draw Hunt does not restrict eligibility for other controlled hunt applications or leftover tag purchases, but successful applicants cannot possess more than one (1) tag each for deer or elk, except where the Commission has authorized possession of additional tags. (5-22-25)T

04. Application Period. The first and second application periods for NR draw hunts and the application period for NR DAV draw hunts will be those published via the Department's website and supplemental brochure. (5-22-25)T

05. Deadline for Claiming Tags and Sale of Unclaimed Tags. (5-22-25)T

a. The dates by which successful applicants must claim tags for NR DAV draw hunts, and NR draw hunts relative to the first and second draws, and the dates on which leftover tags will become available, will be the respective dates published via the Department's website and supplemental brochures. (5-22-25)T

b. Any NR draw hunt tag not purchased and picked up by the published deadline for the first application period will be made available for a second NR draw. (5-22-25)T

c. Any NR draw hunt tag not purchased and picked up by the published deadline for the second application period will be offered in a leftover tag sale on a first-come, first-served basis. Any NR draw hunt tag leftover on or after August 1 may be sold as a second tag in accordance with IDAPA 13.01.04.560. (5-22-25)T

d. Any leftover NR DAV draw hunt tag may be sold on a first-come, first-served basis only to eligible nonresident disabled veterans as first tags. (5-22-25)T

06. Refunds. License fees will not be refunded to unsuccessful applicants, except as provided in IDAPA 13.01.04.601. For consideration of refunds only, applications for NR draw hunts and NR DAV draw hunts will not be considered controlled hunt applications. (5-22-25)T

07. Discounted Application Fee. The Commission finds it appropriate to discount the controlled hunt application fee, as set forth in Section 36-416, Idaho Code, to zero (0) to test the performance of year 2026 NR draw hunts and NR DAV tag draw hunts. (5-22-25)T

08. Hunt Choices. (5-22-25)T

a. Individual or group applications for NR and NR DAV Tag may apply for up to five (5) prioritized hunt choices per application. (5-22-25)T

b. If a group application is drawn whose number of applicants exceeds the number of available tags, that group application will not be selected for that hunt. (5-22-25)T

c. Applications that are not selected for their higher choice hunt will automatically be entered into drawings for their lower choices, provided the lower choices applied for have not been filled. (5-22-25)T

09. Group Application. (5-22-25)T

a. A "group application" for NR draw hunts or NR DAV draw hunts may be submitted by two, three, or four (2, 3, or 4) individuals eligible for the same hunt(s) on the same application. (5-22-25)T

b. If any applicant is ineligible at the time of drawing the applicant will be removed from the application and excluded from the drawing. (5-22-25)T

550. NONRESIDENT DEER AND ELK TAG QUOTAS.

01. General Hunt Tag Quotas. The following number of general hunt tags will be set aside annually and reserved for sale to nonresidents: (3-31-22)

a. ~~Fourteen~~Fifteen thousand five hundred (~~14,000~~15,500) total deer tags (regular and white-tailed deer tags); ~~(3-31-22)~~(5-22-25)T

b. Twelve thousand eight hundred fifteen (12,815) total elk tags (A and B tags)~~;~~. ~~(3-31-22)~~(5-22-25)T

~~**c.** One thousand five hundred (1,500) white-tailed deer tags, available only upon sell out of deer tags referenced in Subsection 550.01.a. (3-31-22)~~

02. Disabled American Veteran Hunt Tag Quotas. The following number of disabled American veteran general hunt tags will be set aside annually and reserved for sale to eligible nonresidents. (3-31-22)

a. Five hundred (500) total disabled American veteran deer tags (regular and white-tailed deer tags); (3-31-22)

b. Three hundred (300) total disabled American veteran elk tags (A and B tags). (3-31-22)

03. Exceptions. Tag sales to the following persons will not be counted in the quotas in Section 550 of these rules: (3-31-22)

a. Unqualified Residents: Persons who have moved into Idaho and by notarized affidavit show proof of their intent to become bona fide Idaho residents but are not yet qualified to purchase a resident license. (3-31-22)

~~**b.** Designated Buyers of unused nonresident tags to which the quota has already applied: an unused nonresident general hunt deer or elk tag, accompanied by a notarized affidavit stating that the tag buyer has not hunted, may be designated to another nonresident for purchase at the regular tag price, by the original buyer or an outfitter or guide retained by the original buyer, or absent such designation, may be sold by the Department on a first-come, first-serve basis. (3-31-22)~~

~~**e**~~**b.** Holders of resident lifetime license certificates who are no longer Idaho residents. (3-31-22)

~~**d**~~**c.** Holders of nonresident junior mentored tags. (3-31-22)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.10 – IDAHO REPORTABLE DISEASES

DOCKET NO. 16-0210-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-605, 39-906, 39-1003, 39-1603, 39-4505(2), 54-1119, 56-1003, and 56-1005, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 16, 2025 **9:30 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m61991eff4894a46b904e33d2c8527179** **Join by meeting number** **Meeting number (access code): 2819 298 1764** **Meeting password: xDhixiNB283** **Meeting password when dialing from a phone or video system: 93449462** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Tuesday, June 17, 2025 **9:30 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=ma22c531f5534be954b1964170044d89a** **Join by meeting number** **Meeting number (access code): 2822 181 7579** **Meeting password: u7VPDppyP33** **Meeting password when dialing from a phone or video system: 87873779** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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

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

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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

Fees will not be increased as a result of this rulemaking.

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

There is not anticipated to be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, Volume 25-4, pages 17 and 18.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25th, 2025.

DATED this 2nd day of May, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
DHWRules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0210-2501
(ZBR Chapter Rewrite)

16.02.10 – IDAHO REPORTABLE DISEASES

000. LEGAL AUTHORITY.
Sections 39-605, 39-1003, 39-1603, and 56-1005, Idaho Code, grant authority to the Board of Health and Welfare to adopt rules protecting the health of the people of Idaho. Section 39-906, Idaho Code, provides for the Director to administer rules adopted by the Board of Health and Welfare. Section 39-4505(2), Idaho Code, gives the Director authority to promulgate rules regarding the identification of blood- or body fluid-transmitted viruses or diseases. Section 56-1003, Idaho Code, gives the Director the authority to adopt rules protecting the health of the people of Idaho and to recommend rules to the Board of Health and Welfare. Section 54-1119, Idaho Code, authorizes the Director to promulgate rules regarding the handling of dead human bodies as needed to preserve and protect the public health. (3-17-22)

001. ~~TITLE AND~~ SCOPE.

~~**01. Title**. These rules are titled IDAPA 16.02.10, "Idaho Reportable Diseases." (3-17-22)~~

~~**02. Scope**.~~ These rules contain the official requirements governing the reporting, control, and prevention of reportable diseases and conditions and requirements to prevent transmission of health hazards from dead human bodies. The purpose of these rules is to identify, control, and prevent the transmission of reportable diseases and conditions within Idaho. ~~(3-17-22)~~( )

002. DOCUMENTS INCORPORATED BY REFERENCE.
~~The documents referenced in Subsections 004.01 through 004.07 of this rule are used as a means of further clarifying these rules.~~ These documents are incorporated by reference and are available at the Idaho State Law Library or at the Department's main office. ~~(3-17-22)~~( )

01. Guideline for Isolation Precautions in Hospitals. Siegel, J.D., et al., "Guideline for Isolation Precautions in Hospitals." Health Care Infection Control Practices Advisory Committee, Atlanta, GA: Centers for Disease Control and Prevention, 2007. (3-17-22)

02. National Notifiable Diseases Surveillance System - Case Definitions. http://ndc.services.cdc.gov/. (3-17-22)

03. Human Rabies Prevention -- United States, 2008. Morbidity and Mortality Weekly Report, May 23, 2008, Vol. 57.RR-3. Centers for Disease Control and Prevention. (3-17-22)

04. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. Infection Control and Hospital Epidemiology, September 2013, Vol. 34, 9. The Society for Healthcare Epidemiology of America. These guidelines are found online at http://www.jstor.org/stable/10.1086/672271. (3-17-22)

05. Compendium of Animal Rabies Prevention and Control, 2016. National Association of State Public Health Veterinarians, Inc., Journal of American Veterinary Medical Association Vol. 248(5), March 1, 2016. This document is found online at http://nasphv.org/documentsCompendia.html. (3-17-22)

06. Standards for Cancer Registries, Volume ~~I~~V~~I~~I, Data Standards and Data Dictionary. North American Association of Central Cancer Registries, ~~Eighteenth~~ Twenty-sixth Edition, Record Layout Version ~~14, September 2013~~ 25, January 2025. ~~(3-17-22)~~( )

07. Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices, 2010. Morbidity and Mortality Weekly Report, Recommendations and Reports, March 19, 2010/59(RR02);1-9. This document is found online at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5902a1.htm. (3-17-22)

~~**003. DISCLOSURE OF INFORMATION.**~~
~~No employee of the Department or Health District may disclose the identity of persons named in disease reports except to the extent necessary for the purpose of administering the public health laws of this state.~~ ~~(3-17-22)~~

0043. -- 009. (RESERVED)

010. DEFINITIONS A THROUGH K.
For the purposes of this chapter, the following definitions apply. (3-17-22)

~~**01. Airborne Precautions**. Methods used to prevent airborne transmission of infectious agents, as described in "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules.~~ ~~(3-17-22)~~

021. Approved Fecal Specimens. Specimens of feces obtained from the designated person who has not taken any antibiotic orally or parenterally for two (2) days prior to the collection of the fecal specimen. The specimen must be collected and transported to the laboratory in a manner appropriate for the test to be performed. (3-17-22)

032. Bite or Other Exposure to Rabies. Bite or bitten means that the skin of the person or animal has been nipped or gripped, or has been wounded or pierced, including scratches, and includes probable contact of saliva with a break or abrasion of the skin. The term "exposure" also includes contact of saliva with any mucous membrane. In the case of bats, even in the absence of an apparent bite, scratch, or mucous membrane contact, exposure may have occurred, as described in "Human Rabies Prevention -- United States,"~~ incorporated in Section 004 of these rules.~~
~~(3-17-22)~~( )

043. Board. The Idaho State Board of Health and Welfare~~ as described in Section 56-1005, Idaho Code~~.
~~(3-17-22)~~( )

054. Cancer Data Registry of Idaho (CDRI). The agency performing cancer registry services under a contractual agreement with the Department as described in Section 57-1703, Idaho Code. (3-17-22)

~~**06. Cancers**. Cancers that are designated reportable include the following as described in Section 57-1703, Idaho Code:~~ ~~(3-17-22)~~

~~**a.** In situ or malignant neoplasms, but excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix.~~ ~~(3-17-22)~~

~~**b.** Benign tumors of the brain, meninges, pineal gland, or pituitary gland.~~ ~~(3-17-22)~~

075. Carrier. A~~ carrier is a~~ person who can transmit a communicable disease to another person, but may not have symptoms of the disease. ~~(3-17-22)~~( )

086. Case.~~ (3-17-22)~~

~~**a.**~~ A person, who has been diagnosed as having a specific disease or condition by a physician or other health care provider~~, is considered a case~~. The diagnosis may be based on clinical judgment, on laboratory evidence, or on both criteria~~. Individual case definitions are described in "National Notifiable Diseases Surveillance System Case Definitions," incorporated in Section 004 of these rules~~, will be evaluated for public health case classification.
~~(3-17-22)~~( )

~~**b.** A laboratory detection of a disease or condition as listed in Section 050 of these rules and as further outlined in Sections 100 through 949 of these rules.~~ ~~(3-17-22)~~

~~**09. Cohort System**. A communicable disease control mechanism in which cases having the same~~

~~disease are temporarily segregated to continue to allow supervision and structured attendance in a daycare or health care facility.~~ ~~(3-17-22)~~

~~10~~07. **Communicable Disease**. A disease that may be transmitted from one (1) person or an animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death. (3-17-22)

~~11~~08. **Contact**. A ~~contact is a~~ person who has been exposed to a case or a carrier of a communicable disease while the disease was communicable, or a person by whom a case or carrier of a communicable disease could have been exposed to the disease. ~~(3-17-22)~~( )

~~12. **Contact Precautions**. Methods used to prevent contact transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules.~~ ~~(3-17-22)~~

~~13~~09. **Daycare**. Care ~~and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood or marriage to the person or persons providing the care, in a place other than the child's or children's own home or homes~~ as described by Section 39-1102, Idaho Code. ~~(3-17-22)~~( )

~~14~~10. **Department**. The Idaho Department of Health and Welfare or its designee. (3-17-22)

~~15~~11. **Director**. The Director of the Idaho Department of Health and Welfare or their designee ~~as described under Sections 56-1003 and 39-414(2), Idaho Code, and Section 950 of these rules~~. ~~(3-17-22)~~( )

~~16~~12. **Division of Public Health Administrator**. A person appointed by the Director to oversee the administration of the Division of Public Health, Idaho Department of Health and Welfare, or their designee. (3-17-22)

~~17. **Droplet Precautions**. Methods used to prevent droplet transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules.~~ ~~(3-17-22)~~

~~18. **Exclusion**. An exclusion for a food service facility means a person is prevented from working as a food employee or entering a food establishment except for those areas open to the general public as outlined in the IDAPA 16.02.19, "Idaho Food Code."~~ ~~(3-17-22)~~

~~19~~13. **Extraordinary Occurrence of Illness Including Clusters**. Rare or novel diseases and unusual outbreaks of illness that may be a risk to the public ~~are considered an extraordinary occurrence of illness.~~ Even in the absence of a defined etiologic agent or toxic substance, clusters of unexplained acute illness and early stage disease symptoms, ~~I~~illnesses related to drugs, foods, contaminated medical devices, contaminated medical products, illnesses related to environmental contamination by infectious or toxic agents, unusual syndromes, or illnesses associated with occupational exposure to physical or chemical agents may be included in this definition. ~~(3-17-22)~~( )

~~20~~14. **Fecal Incontinence**. A condition in which temporarily, as with severe diarrhea, or long-term, as with a child or adult requiring diapers, there is an inability to hold feces in the rectum, resulting in involuntary voiding of stool. (3-17-22)

~~21~~15. **Foodborne Disease Outbreak**. ~~An outbreak is when t~~ Two (2) or more persons experience~~d~~ing a similar illness after ingesting a common food, and epidemiological investigation indicates food as the source of the illness. ~~(3-17-22)~~( )

~~22~~16. **Food Employee**. An individual working with unpackaged food, food equipment or utensils, or food-contact surfaces as defined in IDAPA 16.02.19, "Idaho Food Code." (3-17-22)

~~23~~17. **Health Care Facility**. An establishment organized and operated to provide health care to three (3) or more individuals who are not members of the immediate family. This definition includes hospitals, intermediate

care facilities, residential care and assisted living facilities. (3-17-22)

~~24~~18. **Health Care Provider**. A person who has direct or supervisory responsibility for the delivery of health care or medical services. ~~This includes: licensed physicians, nurse practitioners, physician assistants, nurses, dentists, chiropractors, and administrators, superintendents, and managers of clinics, hospitals, and licensed laboratories.~~ ~~(3-17-22)~~( )

~~25~~19. **Health District**. Any one (1) of the seven (7) public health districts as established by Section 39-409, Idaho Code~~, and described in Section 030 of these rules~~. ~~(3-17-22)~~( )

260. **Health District Director**. Any one (1) of the public health districts' directors appointed by the Health District's Board as described in Section 39-413, Idaho Code, or their designee. (3-17-22)

~~27~~1. **Idaho Food Code**. Idaho Administrative Code that governs food safety, IDAPA 16.02.19, "Idaho Food Code." ~~These rules may be found online at http://adminrules.idaho.gov/rules/current/16/160219.pdf.~~ ~~(3-17-22)~~( )

22. **Investigation**. Public health methods used to determine exposure source, risk factors, susceptible contacts, transmission risks, and prevention measures necessary to limit additional cases of a disease or condition. Investigations may be individual case investigations or epidemiologic investigations of more than one illness. ( )

~~28~~3. **Isolation**. The separation of a person known or suspected to be infected with an infectious agent, or contaminated from chemical or biological agents, from other persons to such places, under such conditions, and for such time as will prevent transmission of the infectious agent or further contamination. ~~The place of isolation will be designated by the Director under Section 56-1003(7), Idaho Code, and Section 065 of these rules.~~ ~~(3-17-22)~~( )

011. DEFINITIONS L THROUGH Z.
For the purposes of this chapter, the following definitions apply. (3-17-22)

01. Laboratory Director. A person ~~who is~~ directly responsible for the operation of a licensed laboratory or their designee. ~~(3-17-22)~~( )

02. Laboratory. A medical diagnostic laboratory that is inspected, licensed, or approved by the Department or licensed according to the provisions of the Clinical Laboratory Improvement Act by the United States Health Care and Financing Administration. Laboratory may also refer to the Idaho State Public Health Laboratory, and to the United States Centers for Disease Control and Prevention. (3-17-22)

03. Livestock. Livestock as defined by the Idaho Department of Agriculture in IDAPA 02.04.03, "Rules Governing Animal Industry." (3-17-22)

04. Medical Record. Hospital or medical records ~~are all those records~~ compiled for the purpose of recording a medical history, diagnostic studies, laboratory tests, treatments, or rehabilitation. ~~Access will be limited to those parts of the record that will provide a diagnosis, or will assist in identifying contacts to a reportable disease or condition. Records specifically exempted by statute are not reviewable.~~ ~~(3-17-22)~~( )

05. Outbreak. An ~~outbreak is an~~ unusual rise in the incidence of a disease. An outbreak may consist of a single case. ~~(3-17-22)~~(3-17-22)

06. Personal Care. The service provided by one (1) person to another for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding, and other services involving direct physical contact. (3-17-22)

07. Physician. A person ~~legally authorized to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho~~ as defined in Section 54-1803, Idaho Code. ~~(3-17-22)~~(3-17-22)

08. Quarantine. The restriction placed on ~~the entrance to and exit from the place or premises where an~~

~~infectious agent or hazardous material exists. The place of quarantine will be designated by the Director or Health District Board~~ a person exposed to an infectious or communicable disease, to a person displaying unknown symptoms, or to a contamination from a chemical, nuclear, or biological agent as defined in Section 56-1003, Idaho Code. ~~(3-17-22)~~( )

09. Rabies Post-Exposure Prophylaxis (rPEP). The administration of a rabies vaccine series with or without the antirabies immune globulin, depending on pre-exposure vaccination status, following a documented or suspected rabies exposure~~, as described in "Use of Reduced (4 Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices," incorporated in Section 004 of these rules~~. ~~(3-17-22)~~( )

~~**10. Rabies Susceptible Animal**. Any animal capable of being infected with the rabies virus. (3-17-22)~~

1~~1~~0. Residential Care Facility. A ~~commercial or non-profit establishment organized and operated to provide a place of residence for three (3) or more individuals who are not members of the same family, but live within the same household. Any restriction for this type of facility is included under restrictions for a health care facility~~ facility as defined in 39-3302(27), Idaho Code. ~~(3-17-22)~~( )

1~~2~~1. Restriction. ~~(3-17-22)~~

~~**a.** To limit the activities~~ The limitation of a person's activities to reduce the risk of transmitting a communicable disease. ~~Activities of individuals are restricted or limited to reduce the risk of disease transmission until such time that they are no longer considered a health risk to others.~~ ~~(3-17-22)~~( )

~~**b.** A food employee who is restricted must not work with exposed food, clean equipment, utensils, linens, and unwrapped single service or single use articles. A restricted employee may still work at a food establishment as outlined in the IDAPA 16.02.19, "Idaho Food Code."~~ ~~(3-17-22)~~

1~~3~~2. Restrictable Disease. A ~~restrictable disease is a~~ communicable disease, which if left unrestricted, may have serious consequences to the public's health. The determination of whether a disease is restrictable is based upon the specific environmental setting and the likelihood of transmission to susceptible persons. ~~(3-17-22)~~( )

1~~4~~3. Severe Reaction to Any Immunization. Any serious or life-threatening condition that results directly from the administration of any immunization against a communicable disease. (3-17-22)

1~~5~~4. Significant Exposure to Blood or Body Fluids. ~~Significant exposure is defined as a~~ A percutaneous injury, contact of mucous membrane or non-intact skin, or contact with intact skin when the duration of contact is prolonged or involves an extensive area, with blood, tissue, or other body fluids as defined in "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis,"~~ incorporated in Section 004 of these rules.~~ ~~(3-17-22)~~( )

~~**16. Standard Precautions**. Methods used to prevent transmission of all infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules.~~ ~~(3-17-22)~~

1~~7~~5. State Epidemiologist. A person employed by the Department to serve as a statewide epidemiologist or their designee. (3-17-22)

1~~8~~6. Suspected Case. A person diagnosed with or thought to have a particular disease or condition by a licensed physician or other health care provider. ~~The suspected diagnosis may be based on signs and symptoms, or on laboratory evidence, or both criteria. Suspected cases of some diseases are reportable as described in Section 050 of these rules.~~ Public health suspected case definitions are described in "National Notifiable Diseases Surveillance System Case Definitions." ~~(3-17-22)~~( )

~~**19. Vaccination of an Animal Against Rabies**. Vaccination of an animal by a licensed veterinarian with a rabies vaccine licensed or approved for the animal species and administered according to the specifications on the product label or package insert as described in the "Compendium of Animal Rabies Prevention and Control," incorporated in Section 004 of these rules.~~ ~~(3-17-22)~~

~~20~~17. **Veterinarian**. Any ~~licensed veterinarian~~ individual as defined in Section 54-2103, Idaho Code. ~~(3-17-22)~~( )

~~21~~18. **Waterborne Outbreak**. ~~An outbreak is when t~~ Two (2) or more persons ~~experience~~ with a similar illness after exposure to water from a common source and ~~an~~ epidemiological ~~analysis implicates the~~ evidence indicates water as the source of the illness. ~~(3-17-22)~~( )

~~22~~19. **Working Day**. ~~A working day is from 8 a.m. to 5 p.m., Monday through Friday, excluding state holidays~~ As defined in 48-1002(1), Idaho Code. ~~(3-17-22)~~( )

012. -- 019. (RESERVED)

020. PERSONS REQUIRED TO REPORT REPORTABLE DISEASES, CONDITIONS, AND SCHOOL CLOSURES.

01. Physician. A licensed physician who diagnoses, treats, or cares for a person with a reportable disease or condition must ~~make a~~ report ~~of such~~ the disease or condition to the Department or Health District ~~as described in these rules~~. The physician is also responsible for reporting diseases and conditions diagnosed or treated by ~~physician assistants, nurse practitioners, or others~~ anyone under the physician's supervision. ~~(3-17-22)~~( )

02. Hospital or Health Care Facility Administrator. The hospital or health care facility administrator must report all persons who are diagnosed, treated, or receive care for a reportable disease or condition in their facility unless the attending physician has reported the disease or condition. (3-17-22)

03. Laboratory Director. The laboratory director must report to the Department or Health District the identification of, or laboratory findings suggestive of, the presence of the organisms, diseases, or conditions listed in ~~Section 050~~ of these rules. ~~(3-17-22)~~( )

04. School Administrator. A school administrator must report diseases and conditions to the Department or Health District ~~as indicated in Section 050 of these rules~~. A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in their opinion, such closing is related to a communicable disease. ~~(3-17-22)~~( )

05. Persons in Charge of Food Establishments. A person in charge of an eating or drinking establishment must report diseases and conditions to the Department or Health District ~~as indicated in Section 050 of these rules and obtain guidance on proper actions needed to protect the public~~. ~~(3-17-22)~~( )

06. Others Required to Report Reportable Diseases. In addition to licensed physicians, reports must also be made by ~~physician assistants, certified nurse practitioners, licensed registered nurses, school health nurses, infection surveillance staff, public health officials, and~~ coroners and other health care providers as described in 39-7702, Idaho Code. ~~(3-17-22)~~( )

021. ACCESS TO MEDICAL RECORDS.
No physician, hospital administrative person, or patient may deny the Department, Health Districts, or the Board access to medical records in discharge of their duties in implementing the reportable disease rules. (3-17-22)

~~**022. PENALTY PROVISIONS.**~~
~~These rules may be enforced under the civil and criminal penalties described in Sections 39-108, 39-109, 39-607, 39-1006, 39-1606, and 56-1008, Idaho Code, and other applicable statutes and rules. Penalties may include fines and imprisonment as specified in Idaho Code.~~ ~~(3-17-22)~~

~~**023. DELEGATION OF POWERS AND DUTIES.**~~
~~The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by the both the Director and the Health District Board.~~ ~~(3-17-22)~~

024~~2~~. -- 029. (RESERVED)

030. WHERE TO REPORT REPORTABLE DISEASES AND CONDITIONS.
~~Subsections 030.01 through 030.09 of this rule provide where information for reporting of suspected, identified, and diagnosed diseases and conditions are to be reported. The diseases and conditions in Sections 100 through 949 of these rules are reportable to the agencies listed in Subsections 030.01 through 030.09 of this rule.~~ ~~(3-17-22)~~

01. Department of Health and Welfare, Bureau of Environmental Health and Communicable Disease ~~Prevention~~ Epidemiology Program. ~~(3-17-22)~~( )

a. Main Office Address: 450 West State Street, 4th Floor, Boise, ID 83720. (3-17-22)

b. Phone: (208) 334-5939 and FAX: (208) 332-7307. (3-17-22)

02. Health District I - Panhandle Health District. The Panhandle Health District covers the counties of Benewah, Bonner, Boundary, Kootenai, and Shoshone. (3-17-22)

a. Main Office Address: 8500 N. Atlas Road, Hayden, ID 83835. (3-17-22)

b. Phone: (208) 772-3920 and FAX: 1-866-716-2599 Toll Free. (3-17-22)

03. Health District II - Public Health Idaho North Central District. The North Central District covers the counties of Clearwater, Idaho, Latah, Lewis, and Nez Perce. (3-17-22)

a. Main Office Address: 215 10th Street, Lewiston, ID 83501. (3-17-22)

b. Phone: (208) 799-3100 and FAX: (208) 799-0349. (3-17-22)

04. Health District III - Southwest District Health. Southwest District Health covers the counties of Adams, Canyon, Gem, Owyhee, Payette, and Washington. (3-17-22)

a. Main Office Address: 13307 Miami Lane, Caldwell, ID 83607. (3-17-22)

b. Phone: (208) 455-5442 and FAX: (208) 455-5350. (3-17-22)

05. Health District IV - Central District Health ~~Department~~. The Central District Health ~~Department~~ covers the counties of Ada, Boise, Elmore and Valley. ~~(3-17-22)~~( )

a. Main Office Address: 707 N. Armstrong Place, Boise, ID 83704. (3-17-22)

b. Phone: (208) 327-8625 and FAX: (208) 327-7100. (3-17-22)

06. Health District V - South Central Public Health District. The South Central Public Health District covers the counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls. (3-17-22)

a. Main Office Address: 1020 Washington Street N., Twin Falls, ID 83301. (3-17-22)

b. Phone: (208) 737-5929 and FAX: (208) 736-3009. (3-17-22)

07. Health District VI - Southeastern Idaho Public Health. The Southeastern Idaho Public Health District covers the counties of Bannock, Bear Lake, Bingham, Butte, Caribou, Franklin, Oneida, and Power. (3-17-22)

a. Main Office Address: 1901 Alvin Ricken Drive, Pocatello, ID 83201. (3-17-22)

b. Phone: (208) 233-9080 and FAX: (208) 233-1916. (3-17-22)

08. Health District VII - Eastern Idaho Public Health ~~District~~. ~~The~~ Eastern Idaho Public Health ~~District~~ covers the counties of Bonneville, Clark, Custer, Fremont, Jefferson, Lemhi, Madison and Teton. ~~(3-17-22)~~( )

a. Main Office Address: 1250 Hollipark Drive, Idaho Falls, ID 83401. (3-17-22)

b. Phone: (208) 533-3152 and FAX: (208) 523-4365. (3-17-22)

09. Cancer Data Registry of Idaho (CDRI). (3-17-22)

a. Main Office Address: 615 N. 7th Street, P.O. Box 1278, Boise, ID 83701. (3-17-22)

b. Phone: (208) 338-5100. (3-17-22)

~~**10. Inter-Agency Notification.** The Health District must notify the Department of reportable diseases and conditions as listed in Section 050 of these rules. (3-17-22)~~

~~**a.** The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of a reportable disease or condition when required in Sections 100 through 949 of these rules. (3-17-22)~~

~~**b.** The Department and the Health District will exchange reported information no later than weekly of all other cases of reportable diseases and conditions. (3-17-22)~~

~~**c.** The Department will notify the Idaho Department of Agriculture of any identified or suspected source of an animal related disease when required in Sections 100 through 949 of these rules. (3-17-22)~~

031. -- 039. (RESERVED)

040. REPORT CONTENTS AND ~~METHOD OF~~ AFTER-HOURS REPORTING.

01. Report Contents. Each report of a reportable disease or condition must include: (3-17-22)

a. The identity and address of the attending licensed physician or the person reporting; (3-17-22)

b. The diagnosed or suspected disease or condition; (3-17-22)

c. The name, current address, telephone number, birth date, age, race, ethnicity, and sex of the individual with the disease or other identifier from whom the specimen was obtained; (3-17-22)

d. The date of onset of the disease or the date the test results were received; and (3-17-22)

e. In addition, laboratory directors must report the identity of the organism or other significant test result. (3-17-22)

~~**02. How To Report.** A report of a case or suspected case may be made to the Department or Health District by telephone, mail, fax, or through electronic disease reporting systems as listed in Section 030 of these rules. (3-17-22)~~

0~~3~~2. After Hours Notification. An after hours report of a disease or condition may be made through the Idaho State EMS Communications Center (State Comm) at (800) 632-8000. ~~A public health official will be contacted regarding the report.~~ ~~(3-17-22)~~( )

041. -- 049. (RESERVED)

050. REPORTABLE OR RESTRICTABLE DISEASES, CONDITIONS AND REPORTING REQUIREMENTS.

Reportable diseases and conditions must be reported to the Department or Health District ~~by those required under Section 020 of these rules~~ and must be investigated to confirm the diagnosis, obtain specific clinical information, determine possible risk factors, identify clusters or outbreaks of the infection, and identify the source of infection. The table below identifies the reportable and restrictable diseases and conditions, the timeframe for reporting, and the person or facility required to report. Restrictions, unless otherwise specified, are for the duration of time that the disease is in a communicable form, other than for Food Employees with Food Service restrictable conditions, who must be managed under IDAPA 16.02.19, "Idaho Food Code".

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS
TABLE 050

Reportable or Restrictable Diseases and Conditions	~~Section in Rule~~	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators ~~(Section 020)~~
~~Acquired Immune Deficiency Syndrome (AIDS), (including CD-4 lymphocyte counts <200 cells/mm3 blood or < 14%)~~	~~100~~	~~Within 3 working days~~	~~None~~	
Amebiasis and Free-living Amebae	~~110~~	Within 3 working days	DC, FS, HC	Food Service Facility
Anthrax (*Bacillus anthracis*)	~~120~~	Immediately	None	
Arboviral Diseases, including suspected cases	~~125~~	Within 3 working days	None	
~~Biotinidase Deficiency~~	~~130~~	~~Within 1 working day (in newborn screening)~~	~~None~~	
Botulism, including suspected cases	~~140~~	Immediately	None	
Brucellosis (*Brucella* species)	~~150~~	Within 1 working day	None	
Campylobacteriosis (*Campylobacter* species)	~~160~~	Within 3 working days	DC, FS, HC	Food Service Facility
Cancer	~~170~~	Report to Cancer Data Registry of Idaho within 180 days of diagnosis or recurrence (including suspected cases)	None	
Chancroid	~~180~~	Within 3 working days	None	
Chlamydia trachomatis Infections	~~190~~	Within 3 working days	HC - ophthalmia neonatorum only	
Cholera (*Vibrio cholerae*)	~~200~~	Within 1 working day	FS, HC, DC	Food Service Facility
~~Congenital Hypothyroidism~~	~~210~~	~~Within 1 working day (in newborn screening)~~	~~None~~	
Conjunctivitis	~~080, 090~~	No reporting required	DC, S	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**~~Section in Rule~~**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators ~~(Section 020)~~**
Cryptosporidiosis (*Cryptosporidium* species)	~~220~~	Within 3 working days	FS, HC, DC	
Cutaneous Fungal Infections	~~080, 090~~	No reporting required	DC, S	
Diarrhea (until common communicable diseases have been ruled out)	~~085~~	No reporting required	FS	
Diphtheria (*Corynebacterium diphtheriae*)	~~230~~	Immediately	DC, FS, HC, S	School
Echinococcosis	~~235~~	Within 3 working days	None	
Encephalitis, Viral or Aseptic	~~240~~	Within 3 working days	None	
Escherichia coli O157:H7 and other Shiga-Toxin Producing *E. coli* (STEC)	~~250~~	Within 1 working day	DC, FS, HC	Food Service Facility School
Extraordinary Occurrence of Illness, including Clusters	~~260~~	Within 1 working day	None	
Fever	~~085~~	No reporting required	FS	
Food Poisoning, Foodborne Illness, and Waterborne Illnesses, including suspected cases and outbreaks	~~270~~	Within 1 working day	None	
~~Galactosemia~~	~~280~~	~~Within 1 working day (in newborn screening)~~	~~None~~	
Giardiasis (*Giardia lamblia*)	~~290~~	Within 3 working days	DC, FS, HC	Food Service Facility
Haemophilus influenzae Invasive Disease	~~300~~	Within 1 working day	DC, S	School
Hantavirus Pulmonary Syndrome	~~310~~	Within 1 working day	None	
Hemolytic-Uremic Syndrome (HUS) or Thrombotic thrombocytopenic purpura-HUS (TTP-HUS)	~~320~~	Within 1 working day	None	
Hepatitis A	~~330~~	Within 1 working day	DC, FS, HC	Food Service Facility
Hepatitis B	~~340~~	Within 1 working day	None	
Hepatitis C	~~350~~	Within 3 working days	None	
Human Immunodeficiency Virus (HIV)	~~360~~	Within 3 working days	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**~~Section in Rule~~**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators ~~(Section 020)~~**
~~Human T-Lymphotropic Virus~~	~~370~~	~~Within 3 working days~~	~~None~~	
Jaundice	~~085~~	No reporting required	FS	
Lead Poisoning	~~380~~	Within 3 working days	None	
Legionellosis	~~390~~	Within 3 working days	None	
Leprosy (Hansen's Disease)	~~400~~	Within 3 working days	None	
Leptospirosis	~~410~~	Within 3 working days	None	
Listeriosis (*Listeria* species)	~~420~~	Within 3 working days	None	
Lyme Disease	~~430~~	Within 3 working days	None	
Malaria (*Plasmodium* species)	~~440~~	Within 3 working days	None	
~~Maple Syrup Urine Disease~~	~~450~~	~~Within 1 working day (in newborn screening)~~	~~None~~	
Measles (Rubeola)	~~460~~	Within 1 working day	DC, HC, S	School
Meningitis, Viral or Aseptic	~~470~~	Within 3 working days	None	
Methicillin-resistant (MRSA and Vancomycin-resistant (VRSA) *Staphylococcus aureus* ~~(MRSA)~~ Invasive Disease	~~475~~	Within 3 working days	None	**Note:** Only Laboratory Directors need to report.
Methicillin-resistant *Staphylococcus aureus* (MRSA) Non-Invasive Disease	~~475, 080, 090~~	No reporting required	DC, FS, HC, S	
Mumps	~~480~~	Within 3 working days	DC, S, HC	School
Myocarditis, Viral	~~490~~	Within 3 working days	None	
Neisseria gonorrhoeae Infections	~~500~~	Within 3 working days	HC-ophthalmia neonatorum only	
Neisseria meningitidis Invasive Disease	~~510~~	Within 1 working day	DC, HC, S	School
Norovirus	~~520~~	Within 1 working day	DC, FS, HC, S	
Novel Influenza A Virus	~~522~~	Within 1 working day	DC, FS, HC, S	
Pediculosis	~~080, 090~~	No reporting required	DC, S	
Pertussis (*Bordetella pertussis*)	~~530~~	Within 1 working day	DC, HC, S	School
~~Phenylketonuria (PKU)~~	~~540~~	~~Within 1 working day (in newborn screening)~~	~~None~~	
Plague (*Yersinia pestis*)	~~550~~	Immediately	HC, S	School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**~~Section in Rule~~**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators ~~(Section 020)~~**
Pneumococcal Invasive Disease in Children less than Eighteen (18) Years of Age *(Streptococcus pneumoniae)*	~~560~~	Within 3 working days	DC, S	School
Pneumocystis Pneumonia (PCP)	~~570~~	Within 3 working days	None	
Poliomyelitis	~~580~~	Within 1 working day	DC	School
Psittacosis	~~590~~	Within 3 working days	None	
Q Fever	~~600~~	Within 1 working day	None	
Rabies - Human, Animal, and Post-Exposure Prophylaxis (rPEP)	~~610~~	Immediately (human), Within 1 working day (animal or rPEP)	None	
Relapsing Fever, Tick-borne and Louse-borne	~~620~~	Within 3 working days	None	
Respiratory Syncytial Virus (RSV)	~~630~~	Within 1 working day	None	**Note:** Only Laboratory Directors need to report.
~~Reye Syndrome~~	~~640~~	~~Within 3 working days~~	~~None~~	
~~Rocky Mountain~~ Spotted Fever Ricketsiosis	~~650~~	Within 3 working days	None	
Rubella (including Congenital Rubella Syndrome)	~~660~~	Within 1 working day	DC, HC, S	School
Salmonellosis (including Typhoid Fever) (*Salmonella* species)	~~670~~	Within 1 working day	DC, FS, HC	Food Service Facility
Scabies	~~080, 090~~	No reporting required	DC, S	
Severe Acute Respiratory Syndrome (SARS), including suspected cases	~~680~~	Within 1 working day	DC, S	School
Severe Reaction to Any Immunization	~~690~~	Within 1 working day	None	
Shigellosis (*Shigella* species)	~~700~~	Within 1 working day	DC, FS, HC, S	Food Service Facility School
Smallpox, including suspected cases	~~710~~	Immediately	DC, HC, S	School
Sore Throat with Fever	~~085~~	No reporting required	FS	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**~~Section in Rule~~**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators ~~(Section 020)~~**
Staphylococcal Infections other than MRSA	~~080, 085, 090~~	No reporting required	DC, FS, S	
Streptococcal Pharyngeal Infections	~~080, 090~~	No reporting required	DC, S	
Streptococcus pyogenes (group A strep), Invasive or Resulting in Rheumatic Fever	~~720~~	Within 3 working days	DC, HC, S	School
Syphilis	~~730~~	Within 3 working days	None	
Taeniasis	~~085~~	No reporting required	FS	
Tetanus	~~740~~	Within 3 working days	None	
Toxic Shock Syndrome	~~750~~	Within 3 working days	None	
Transmissible Spongiform Encephalopathies (TSE), including Creutzfeldt-Jakob Disease (CJD) and Variant CJD (vCJD)	~~760~~	Within 3 working days	None	
Trichinosis	~~770~~	Within 3 working days	None	
Tuberculosis (*Mycobacterium tuberculosis*)	~~780~~	Within 3 working days	DC, FS, HC, S	School Food Service Facility
Tularemia (*Francisella tularensis*)	~~790~~	Immediately; Identification of *Francisella tularensis* - within 1 working day	None	
Uncovered and Open or Draining Skin Lesions with Pus, such as a Boil or Open Wound	~~085~~	No reporting required	FS	
Varicella (chickenpox)	~~080, 090~~	No reporting required	DC, S	
Viral Hemorrhagic Fever		Immediately	DC, FS, HC, S	
Vomiting (until noninfectious cause is identified)	~~085~~	No reporting required	FS	
Yersiniosis (*Yersinia enterocolitica* and *Yersinia pseudotuberculosis*)	~~810~~	Within 3 working days; Identification of *Yersinia pestis* - immediately	FS	

~~(3-17-22)~~( )

~~051. -- 059. (RESERVED)~~

~~060. TESTING FOR CERTAIN REPORTABLE DISEASES WHEN INFORMED CONSENT IS NOT POSSIBLE.~~

~~Under Section 39-4504, Idaho Code, a licensed physician may order blood or body fluid tests for hepatitis viruses, malaria, syphilis, or the human immunodeficiency virus (HIV) when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services.~~ ~~(3-17-22)~~

061~~51~~. -- 064. (RESERVED)

065. INVESTIGATION AND CONTROL OF REPORTABLE DISEASES.

01. Responsibility and Authority. The Department will use all reasonable means to confirm in a timely manner any case or suspected case of a reportable disease or condition, and will determine, when possible, all sources of infection and the extent of exposure. Reports of diseases and conditions enumerated in this chapter will be investigated. Investigations may be made when the ~~Division of Public Health Administrator, Health District Director, or state epidemiologist~~ Department or Health District determines a disease to be of public health significance. ~~(3-17-22)~~( )

a. Every licensed physician or other health care provider attending to a person with a reportable disease or condition must ~~report the case or suspected case, as described in Section 050 of these rules. They must instruct~~ inform the person on applicable control measures as outlined in ~~Sections 100 through 949 of~~ these rules and cooperate with the Department in the investigation and control of the disease or condition. ~~(3-17-22)~~( )

b. Any person providing emergency or medical services who believes they have experienced a significant exposure to blood or bodily fluids ~~as defined in Subsection 011.15 of these rules~~ may report said exposure as soon as possible ~~or within fourteen (14) days of the occurrence~~ to the Department ~~on a significant exposure report form~~. When~~, in~~ the state epidemiologist's ~~judgment,~~ judges a significant exposure has occurred, the Department will inform the exposed individual that they may have been exposed to the HIV or HBV virus, or that there is no information available based on the Department's current HIV or HBV registry and will recommend appropriate counseling and testing for the exposed individual. ~~(3-17-22)~~( )

~~02. Inspection -- Right of Entry. The Department may enter private or public property for the purpose of administering or enforcing the provisions of these rules under the authority and constraints granted by Section 56-1009, Idaho Code.~~ ~~(3-17-22)~~

0~~3~~2. Inviolability of Placards. If it is necessary to use placards, it is unlawful for any person to interfere with, conceal, mutilate or tear down any notices or placards on any house, building or premises placed by the Department. Such placards can only be removed by the health official. (3-17-22)

0~~4~~3. Verification of Diagnosis and Case Classification. Cases of diseases or conditions reported to the Department will be treated as such upon the statement of the attending licensed physician or other health care provider, unless there is reason to doubt the diagnosis. Final decision as to the ~~diagnosis~~ case classification for administrative purposes will rest with the Division of Public Health Administrator or Health District Director. ~~(3-17-22)~~( )

0~~5~~4. Closure of Schools and Places of Public Assembly. The Director may order the closing of any public, parochial, or private school, or other place of public assembly when, in their opinion, such closing is necessary to protect public health. The school or other place of public assembly must not reopen until permitted by the health official. (3-17-22)

0~~6~~5. Transportation of Patients With Communicable Disease. No person with a reportable disease in a communicable form, who is under orders of isolation, nor any contact who is restricted under an order of quarantine, may travel or be transported from one place to another without the permission of the Division of Public Health Administrator or Health District Director. An exception may be made in instances where the patient ~~is to~~ will be admitted directly to a hospital or treatment facility, provided adequate precautions are taken to prevent ~~dissemination~~ transmission of the disease by the patient enroute to the hospital or treatment facility. ~~(3-17-22)~~( )

07~~6~~. **Order to Report for Examination**. The Division of Public Health Administrator or Health District Director may issue an order to report for examination. An order to report for examination must be served by delivering one (1) copy to the person to be examined, one (1) copy to the prosecuting attorney of the county or city in which the person resides, and filing one (1) copy bearing the notation of time and place of service and the signature of the person serving the notice with the issuing health authority. (3-17-22)

08~~7~~. **Order for Isolation**. The Division of Public Health Administrator or Health District Director may issue and withdraw an order for isolation if they determine that it is necessary to protect the public from a significant risk of the spread of infectious or communicable diseases or from contamination from chemical or biological agents. ~~Orders for isolation must be executed as described in Subsections 065.08.a. and 065.08.b. of this rule.~~ ~~(3-17-22)~~( )

a. The order for isolation must be executed as follows: (3-17-22)

i. One (1) copy to the individual being isolated; (3-17-22)

ii. One (1) copy to the attending licensed physician; (3-17-22)

iii. One (1) copy to the prosecuting attorney of the county or city in which the person resides; and (3-17-22)

iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order. (3-17-22)

b. The issuing officer will make an assessment and identify the least restrictive means of isolation that effectively protects unexposed and susceptible individuals from the public health threat. Orders of isolation require the individual to isolate himself at a certain place or places, and may require specific precautions to be taken when outside a designated place of isolation as the issuing officer deems appropriate and necessary. If the place of isolation is other than the individual's place of residence, a copy of the order must be provided to the person in charge of that place. (3-17-22)

c. The Division of Public Health Administrator or Health District Director will withdraw an order for isolation once it is determined there is no longer a significant threat to the public's health posed by the individual under order for isolation. (3-17-22)

09~~8~~. **Order for Quarantine**. The Division of Public Health Administrator or Health District Director is empowered whenever a case of any communicable disease occurs in any household or other place within their jurisdiction and in their opinion it is necessary that persons residing within must be kept from contact with the public, to ~~declare the house, building, apartment, or room a place of quarantine and to~~ require that no persons will leave or enter during the period of quarantine except with specific permission of the issuing officer. ~~Orders for quarantine must be executed as described in Subsections 065.09.a. and 065.09.b. of this rule.~~ ~~(3-17-22)~~( )

a. The order for quarantine must be executed as follows: (3-17-22)

i. One (1) copy to any individual being quarantined; (3-17-22)

ii. One (1) copy to the attending licensed physician; (3-17-22)

iii. One (1) copy to the prosecuting attorney of the county or city in which the quarantine occurs; (3-17-22)

iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order; and (3-17-22)

v. One (1) copy to the person in charge or owner of the place of quarantine. (3-17-22)

b. The issuing officer will make an assessment and identify the least restrictive timeframe of

quarantine that effectively protects unexposed and susceptible individuals to the infection of public health threat. (3-17-22)

c. The Division of Public Health Administrator or Health District Director will withdraw an order for quarantine when they determine there is no longer a significant threat to the public's health posed by the individual or premises under the order for quarantine. (3-17-22)

~~10~~09. **Sexually Transmitted Infection Contacts**. Any person infected with a sexually transmitted infection (venereal disease) as defined in Section 39-601, Idaho Code, is required to provide the name, address, and telephone number(s) of all persons from whom the disease may have been acquired and to whom the disease may have been transmitted, when such information is requested by the Department or Health District. (3-17-22)

066. -- 067. (RESERVED)

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

01. Embalming. (3-17-22)

a. The Division of Public Health Administrator or Health District Director may order a dead human body to be embalmed or prohibit embalming to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. (3-17-22)

b. The dead human body of a person suspected of or confirmed as having a viral hemorrhagic fever at the time of death must not be embalmed, but wrapped in sealed leak-proof material and cremated or buried. (3-17-22)

02. Burial. The Division of Public Health Administrator or Health District Director may order a dead human body to be buried or cremated, or prohibit burial or cremation, and may specify a time frame for final disposition to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. ~~As required in Section 39-268, Idaho Code, all orders of cremation will be approved by the coroner and the coroner will be notified of prohibitions of cremation ordered by the Administrator or Director.~~ ~~(3-17-22)~~( )

03. Notification of Health Hazard. Any person authorized to release a dead human body of a person suspected of or confirmed as having a prior disease, a viral hemorrhagic fever, other infectious health hazard, or contaminated with a hazardous substance, must notify the person taking possession of the body and indicate necessary precautions on a written notice to accompany the body. (3-17-22)

069. (RESERVED)

070. SPECIAL DISEASE INVESTIGATIONS.
The Department may conduct special investigations of diseases or conditions to identify causes and means of prevention. All records of interviews, reports, studies, and statements obtained by or furnished to the Department or other authorized agency are confidential for the identity of all persons involved. Release of information to the Department as required or permitted by these rules does not subject any party furnishing such information to an action for damages as provided under IDAPA 16.05.01, "Use and Disclosure of Department Records." (3-17-22)

071. -- 079. (RESERVED)

080. DAYCARE FACILITY - REPORTING AND CONTROL MEASURES.

01. Readily Transmissible Diseases. Daycare reportable and restrictable diseases are those diseases that are readily transmissible among children and staff in daycare ~~facilities as listed under Section 050 of these rules~~. ~~(3-17-22)~~( )

02. Restrictable Disease - Work. A person who is diagnosed to have a daycare restrictable disease must not work in any occupation in which there is direct contact with children in a daycare facility, as long as the disease is in a communicable form. (3-17-22)

03. Restrictable Disease - Attendance. A child who is diagnosed to have a daycare restrictable disease must not attend a daycare facility as long as the disease is in a communicable form. This restriction may be removed by the written certification of a licensed physician, public health nurse or school nurse that the person's disease is no longer communicable. (3-17-22)

04. Prevention of the Transmission of Disease. When satisfactory measures have been taken to prevent the transmission of disease, the affected child or employee may continue to attend or to work in a daycare facility if approval is obtained from the Department or Health District. (3-17-22)

081. -- 084. (RESERVED)

085. FOOD SERVICE FACILITY - REPORTING AND CONTROL MEASURES.

01. Food or Beverage Transmitted Disease in a Communicable Form. ~~Under Section 050 of these rules, a~~ A person who is determined to have ~~one (1) or more of the~~ a diseases or conditions listed in this chapter as restrictable for food establishments must not work as a food employee as long as the disease is in a communicable form. ~~(3-17-22)~~( )

02. Food Employee Health Examination. The Division of Public Health Administrator may require a food employee to submit to an examination to determine the presence of a disease that can be transmitted by means of food when there is reasonable cause to believe the food employee is afflicted with a disease listed ~~in Section 050 of these rules~~ as restrictable for food establishments and that disease is in a communicable form. ~~(3-17-22)~~( )

03. Notification of Disease in a Communicable Form. If the person in charge of an eating or drinking establishment has reason to suspect that any employee has a disease ~~listed in Section 050 of these rules~~ as restrictable for food establishments, and that disease is in a communicable form, the person in charge must immediately notify the Department or Health District and obtain guidance on proper actions needed to protect the public. ~~(3-17-22)~~( )

086. -- 089. (RESERVED)

090. SCHOOL - REPORTING AND CONTROL MEASURES.

01. Restrictable Diseases. School reportable and restrictable diseases are those diseases that are readily transmissible among students and staff in schools as listed ~~under Section 050 of~~ in these rules. ~~(3-17-22)~~( )

02. Restrictions - Work. Any person who is diagnosed to have a school restrictable disease must not work in any occupation that involves direct contact with students in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

03. Restrictions - Attendance. Any person who is diagnosed with or reasonably suspected to have a school restrictable disease must not attend a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

04. Determination Disease Is No Longer Communicable. A licensed physician, public health nurse, school nurse or other person designated by the Department or Health District may determine when a person with a school restrictable disease is no longer communicable. (3-17-22)

05. School Closure. A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in their opinion, such closing is related to a communicable disease. (3-17-22)

091. HANDLING OF REPORT.

The Department and Health Districts will exchange reported information within one (1) working day. The Department will notify the Idaho Department of Agriculture and any other necessary agency of any identified source

or suspected source of any reported case of the following diseases: ( )

01. **Anthrax**; ( )

02. **Brucellosis**; ( )

03. **Leptospirosis**; ( )

04. **Lyme Disease**; ( )

05. **Plague**; ( )

06. **Psittacosis**; ( )

07. **Q Fever**; ( )

08. **Trichinosis**; and ( )

09. **Tularemia**. ( )

092. RESTRICTIONS.

01. **Restrictions - Daycare Facility**. A person with the following diseases must not attend a daycare facility while fecally incontinent and must not work in any occupation that provides personal care to children while the disease is in a communicable form, unless otherwise specified: ( )

a. Amebiasis and Free-Living Amebae; ( )

b. Campylobacteriosis; ( )

c. Cholera; ( )

d. Conjunctivitis; ( )

e. Cryptosporidiosis; ( )

f. Cutaneous Fungal Infections; ( )

g. Diphtheria; ( )

h. Escherichia Coli O157:H7 and Other Shiga-Toxin Producing E. Coli (STEC); ( )

i. Giardiasis; ( )

j. Haemophilus Influenzae Invasive Disease; ( )

k. Hepatitis A; ( )

l. Measles (Rubeola); ( )

m. Methicillin-Resistant Staphylococcus Aureus (MRSA); ( )

n. Mumps; ( )

o. Neisseria Meningitidis Invasive Disease; ( )

p. Norovirus; ( )

g. Novel A Influenza Virus; ( )

r. Pediculosis; ( )

s. Pertussis; ( )

t. Plague; ( )

u. Pneumococcal Invasive Disease In Children Less Than Eighteen Years Of Age; ( )

v. Poliomyelitis; ( )

w. Rubella – Including Congenital Rubella Syndrome; ( )

x. Salmonellosis; ( )

y. Scabies; ( )

z. Severe Acute Respitory Syndrome (SARS), including suspected cases; ( )

aa. Shigellosis; ( )

bb. Smallpox; ( )

cc. Staphylococcal Infections Other than MRSA; ( )

dd. Streptococcal Pharyngeal Infections; ( )

ee. Streptococcus Pyogenes (Group A Strep) Infections; ( )

ff. Tuberculosis; ( )

gg. Varicella (Chickenpox); and ( )

hh. Viral Hemorrhagic Fever. ( )

02. Restrictions - Food Service Facility. A symptomatic person with the following diseases is restricted from working as a food employee while communicable, unless otherwise specified: ( )

a. Amebiasis and Free-Living Amebae; ( )

b. Campylobacteriosis; ( )

c. Cholera; ( )

d. Cryptosporidiosis; ( )

e. Diarrhea; ( )

f. Diphtheria; ( )

g. Escherichia Coli O157:H7 and Other Shiga-Toxin Producing E. Coli (STEC); ( )

h. Fever; ( )

i. Giardiasis; ( )

j. Hepatitis A; ( )

k. Jaundice; ( )

l. Methicillin-Resistant Staphylococcus Aureus (MRSA); ( )

m. Norovirus; ( )

n. Novel A Influenza Virus; ( )

o. Salmonellosis, Including Typhoid Fever; ( )

p. Shigellosis; ( )

q. Sore Throat with Fever; ( )

r. Staphylococcal Infections Other Than MRSA; ( )

s. Taeniasis; ( )

t. Tuberculosis; ( )

u. Uncovered and Open or Draining Skin Lesions with Pus; ( )

v. Vomiting; ( )

w. Yersiniosis; and ( )

x. Viral Hemorrhagic Fever. ( )

03. Restrictions - Health Care Facility. A symptomatic person with the following diseases must not provide personal care to persons in a health care facility unless otherwise specified: ( )

a. Amebiasis and Free-Living Amebae; ( )

b. Campylobacteriosis; ( )

c. Chlamydia Trachomatis; ( )

d. Cholera; ( )

e. Cryptosporidiosis; ( )

f. Diphtheria; ( )

g. Escherichia Coli O157:H7 and Other Shiga-Toxin Producing E. Coli (STEC); ( )

h. Giardiasis; ( )

i. Hepatitis A; ( )

j. Measles (Rubeola); ( )

k. Methicillin-Resistant Staphylococcus Aureus (MRSA); ( )

l. Mumps; ( )

m. Neisseria Meningitidis Invasive Disease; ( )

n. Norovirus; ( )

o. Novel Influenza A Virus; ( )

p. Pertussis; ( )

q. Plague; ( )

r. Rubella – Including Congenital Rubella Syndrome; ( )

s. Salmonellosis; ( )

t. Shigellosis; ( )

u. Smallpox; ( )

v. Streptococcus Pyogenes (Group A Strep) Infections; ( )

w. Tuberculosis; and ( )

x. Viral Hemorrhagic Fever. ( )

04. Restrictions - School. A person with the following diseases must not attend a private, parochial, charter, or public school while fecally incontinent and must not work in any occupation that involves direct contact with students in a private, parochial, charter, or public school while the disease is in a communicable form, unless otherwise specified: ( )

a. Conjunctivitis; ( )

b. Cutaneous Fungal Infections; ( )

c. Diphtheria; ( )

d. Haemophilus Influenzae Invasive Disease; ( )

e. Measles (Rubeola); ( )

f. Methicillin-Resistant Staphylococcus Aureus (MRSA); ( )

g. Mumps; ( )

h. Neisseria Meningitidis Invasive Disease; ( )

i. Norovirus; ( )

j. Novel A Influenza Virus; ( )

k. Pediculosis; ( )

l. Pertussis; ( )

m. Plague; ( )

n. Pneumococcal Invasive Disease In Children Less Than Eighteen Years Of Age; ( )

o. Polio; ( )

p. Rubella – Including Congenital Rubella Syndrome; ( )

q. Scabies; ( )

r. Severe Acute Respiratory Syndrome (SARS), including suspect cases; ( )

s. Shigellosis; ( )

t. Smallpox; ( )

u. Staphylococcal Infections, other than MRSA; ( )

v. Streptococcal Pharyngeal Infections; ( )

w. Streptococcus Pyogenes (Group A Strep) Infections; ( )

x. Tuberculosis; ( )

y. Varicella (Chickenpox); and ( )

z. Viral Hemorrhagic Fever. ( )

093. TESTING WITHOUT INFORMED CONSENT.
A physician may order blood tests for the following diseases when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services, as per Section 39-4905, Idaho Code: ( )

01. Hepatitis A; ( )

02. Hepatitis B; ( )

03. Hepatitis C; ( )

04. HIV; ( )

05. Malaria; and ( )

06. Syphilis. ( )

09~~1~~4. -- 099. (RESERVED)

REPORTABLE DISEASES ~~AND~~ WITH SPECIAL CONTROL MEASURES
(Sections 100-949)

~~**100. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**~~

~~**01. Reporting Requirements.** Each case of acquired immune deficiency syndrome (AIDS) that meets the current case definition established by the Centers for Disease Control and Prevention must be reported to the Department or Health District within three (3) working days of identification. Positive laboratory tests for HIV Antibody, HIV Antigen (protein or nucleic acid), HIV culture or other tests that indicate prior or existing HIV infection or CD-4 lymphocyte counts of less than two hundred (200) per cubic millimeter (mm3) of blood or less than or equal to fourteen percent (14%) must be reported. (3-17-22)~~

~~**02. Investigation.** Each reported case of AIDS must be investigated to obtain specific clinical~~

~~information, to identify possible sources, risk factors, and contacts. Other manifestations of HIV infection as defined by the Centers for Disease Control and Prevention may be investigated.~~ ~~(3-17-22)~~

10~~1~~0. -- 109. (RESERVED)

110. AMEBIASIS AND FREE-LIVING AMEBAE.

01. Reporting Requirements. Each case of amebiasis or infection with free-living amebae (*Ancanthamoeba* spp., *Balamuthia mandrillaris*, or *Naegleria fowleri*) must be reported ~~to the Department or Health District~~ within three (3) working days of identification. ~~(3-17-22)~~( )

~~**02. Investigation**. Each reported case of infection with free-living amebae must be investigated to determine the source of infection. Each reported case of amebiasis must be investigated to determine whether the person with amebiasis is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility.~~ ~~(3-17-22)~~

0~~3~~2. **Restrictions - Daycare Facility**. A person excreting *Entamoeba histolytica* must not attend a daycare facility while fecally incontinent and must not work in any occupation in which they provide personal care to children in a daycare facility, unless an exemption is made by the Department or Health District. (3-17-22)

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or (3-17-22)

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. (3-17-22)

043. **Restrictions - Food Service Facility**. A symptomatic person excreting *Entamoeba histolytica* is restricted from working as a food employee. (3-17-22)

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or (3-17-22)

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. (3-17-22)

0~~5~~4. **Restrictions - Health Care Facility**. A person excreting *Entamoeba histolytica* must not work in any occupation in which they provide personal care to persons confined to a health care facility, unless an exemption is made by the Department or Health District. (3-17-22)

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or (3-17-22)

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. (3-17-22)

0~~6~~5. **Restrictions - Household Contacts**. A member of the household in which there is a case of amebiasis may not work in any occupations in ~~Subsections 110.03 through 110.05 of this rule~~ listed in this Section, unless approved by the Department or Health District. The household member must be asymptomatic and have at least one (1) approved fecal specimen found to be negative for ova and parasites on examination by a licensed laboratory prior to being approved for work. ~~(3-17-22)~~( )

111. -- 1~~19~~59. (RESERVED)

~~**120. ANTHRAX.**~~

~~**01. Reporting Requirements**. Each case or suspected case of anthrax in humans must be reported to the Department or Health District immediately, at the time of identification, day or night.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of anthrax must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of infection.~~ ~~(3-17-22)~~

~~**03. Handling of Report**. The Department and Health District will exchange reported information within one (1) working day of any reported case of anthrax. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of anthrax. (3-17-22)~~

~~**121. -- 124. (RESERVED)**~~

~~**125. ARBOVIRAL DISEASES.**~~

~~**01. Reporting Requirements**. Each case of suspected or confirmed arboviral disease must be reported to the Department or Health District within three (3) working days of identification. Arboviral diseases include, but are not limited to, those caused by the following viruses: California encephalitis, chikungunya, Colorado tick fever, Crimean-Congo hemorrhagic fever, dengue (all subtypes), eastern equine encephalitis, Heartland, Jamestown Canyon, Japanese encephalitis, Keystone, La Crosse, Mayaro, O'nyong-nyong, Powassan, Rift Valley fever, Ross River, St. Louis encephalitis, snowshoe hare, tick-borne encephalitis, Toscana, trivittatus, Venezuelan equine encephalitis, West Nile, western equine encephalitis, yellow fever, and Zika. (3-17-22)~~

~~**02. Investigation**. Each reported case of arboviral disease must be investigated to confirm the diagnosis, identify the source of infection, and determine if actions need to be taken to prevent additional cases. (3-17-22)~~

~~**126. -- 129. (RESERVED)**~~

~~**130. BIOTINIDASE DEFICIENCY.**~~
~~Each case or suspected case of biotinidase deficiency must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~**131. -- 139. (RESERVED)**~~

~~**140. BOTULISM.**~~

~~**01. Reporting Requirements**. Each case or suspected case of botulism must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)~~

~~**02. Investigation**. Each reported case of botulism must be investigated to confirm the diagnosis, determine if other persons have been exposed to *botulinum* toxins, and identify the source of the disease. (3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day on any reported case of botulism. (3-17-22)~~

~~**141. -- 149. (RESERVED)**~~

~~**150. BRUCELLOSIS.**~~

~~**01. Reporting Requirements**. Each case of brucellosis must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of brucellosis must be investigated to confirm the diagnosis and identify the source of the disease. (3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day of any reported case of brucellosis. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the disease. (3-17-22)~~

~~**151. -- 159. (RESERVED)**~~

160. CAMPYLOBACTERIOSIS.

~~**01. Reporting Requirements**. Each case of campylobacteriosis must be reported to Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of campylobacteriosis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection and identify the source of the disease.~~ ~~(3-17-22)~~

0~~3~~1. **Restrictions - Daycare Facility**. A person excreting *Campylobacter* must not provide personal care in a daycare and an fecally incontinent person excreting *Campylobacter* must not attend a daycare facility unless an exemption is obtained from the Department or Health District. Before returning to work or daycare, the person must provide at least two (2) successive approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show *Campylobacter* upon testing by a licensed laboratory. (3-17-22)

~~**04. Restrictions - Food Service Facility**. A symptomatic person excreting *Campylobacter* is restricted from working as a food employee.~~ ~~(3-17-22)~~

0~~5~~2. **Restrictions - Health Care Facility**. A person excreting *Campylobacter* must not provide personal care to persons in a health care facility unless an exemption is obtained from the Department or Health District. Before returning to work, the person must provide at least two (2) successive approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show *Campylobacter* upon testing by a licensed laboratory. (3-17-22)

161. -- 169. (RESERVED)

170. CANCER.

~~**01. Reporting Requirements**. Cancer is to be reported within one hundred and eighty (180) days of its diagnosis or recurrence to the Cancer Data Registry of Idaho (CDRI).~~ ~~(3-17-22)~~

~~**02. Handling of Report**. All data reported to the CDRI is available for use in aggregate form for epidemiologic analysis of the incidence, prevalence, survival, and risk factors associated with Idaho's cancer experience. Disclosure of confidential information for research projects must comply with the CDRI's confidentiality policies as well as IDAPA 16.05.01, "Use and Disclosure of Department Records."~~ ~~(3-17-22)~~

0~~3~~1. **Cancers Designated as Reportable**. Cancers that are designated reportable to the CDRI ~~include the following as~~ are described in Section 57-1703, Idaho Code. ~~(3-17-22)~~( )

~~**a.** Each in-situ or malignant neoplasm diagnosed by histology, radiology, laboratory testing, clinical observation, autopsy, or suggested by cytology is reportable, excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix.~~ ~~(3-17-22)~~

~~**b.** Benign neoplasms are reportable if occurring in the central nervous system including the brain, meninges, pineal gland, or pituitary gland.~~ ~~(3-17-22)~~

~~e~~a. The use of the words "apparently," "appears to," "comparable with," "compatible with," "consistent with," "favor," "malignant appearing," "most likely," "presumed," "probable," "suspected," "suspicious," or "typical" is sufficient to make a case reportable. (3-17-22)

~~d~~b. The use of the words "questionable," "possible," "suggests," "equivocal," "approaching," "rule out," "potentially malignant," or "worrisome," is not sufficient to make a case reportable. (3-17-22)

0~~4~~2. **Report Content**. Each reported case must include the patient's name, demographic information, date of diagnosis, primary site, metastatic sites, histology, stage of disease, initial treatments, subsequent treatment, and survival time. Reporting of cases must adhere to cancer reporting standards as provided in "Standards for Cancer Registries, Vol. II." ~~as incorporated by reference in Section 004 of these rules.~~ ~~(3-17-22)~~( )

0~~5~~3. **Reported By Whom**. Every private, federal, or military hospital, out-patient surgery center, radiation treatment center, pathology laboratory, or physician providing a diagnosis or treatment related to a

reportable cancer is responsible for reporting or furnishing cancer-related data, including annual follow-up, to CDRI. (3-17-22)

171. -- ~~179.~~ ~~(RESERVED)~~

~~180. CHANCROID.~~

~~01. Reporting Requirements~~. ~~Each case of chancroid must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation and Notification of Contacts~~. ~~Each reported case of chancroid must be investigated to determine the source and extent of contact follow-up that is required. Each person diagnosed with chancroid is required to inform all sexual contacts that they have been exposed to a sexually transmitted infection, or to provide specific information to health officials in order to locate these contacts. The contacts must be notified of the disease in order to be examined and treated according to Section 39-605, Idaho Code.~~ ~~(3-17-22)~~

~~181. -- 189. (RESERVED)~~

~~190. CHLAMYDIA TRACHOMATIS.~~

~~01. Reporting Requirements~~. ~~Each case of *Chlamydia trachomatis* infection must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of *Chlamydia trachomatis* pelvic inflammatory disease may be investigated to determine the extent of contact follow-up that is required.~~ ~~(3-17-22)~~

~~03. Prophylaxis of Newborns.~~ ~~Prophylaxis against *Chlamydia trachomatis* ophthalmia neonatorum is required in IDAPA 16.02.12, "Newborn Screening."~~ ~~(3-17-22)~~

~~04. Restrictions -- Health Care Facility~~. ~~A person with *Chlamydia trachomatis* ophthalmia neonatorum in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals" as incorporated by reference in Section 004 of these rules.~~ ~~(3-17-22)~~

~~191. --~~199. (RESERVED)

200. CHOLERA.

~~01. Reporting Requirements~~. ~~Each case or suspected case of cholera must be reported to the Department or Health District within one (1) working day.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of cholera must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify contacts, carriers, and the source of the infection.~~ ~~(3-17-22)~~

~~03. Handling of Report~~. ~~The Department and the Health District will exchange reported information within one (1) working day on any reported case of cholera.~~ ~~(3-17-22)~~

~~04. Restrictions -- Daycare Facility~~. ~~A person excreting *Vibrio cholerae* must not attend a daycare facility while fecally incontinent and must not work in any occupation that provides personal care to children in a daycare facility while the disease is in a communicable form, unless an exemption is obtained from the Department or Health District.~~ ~~(3-17-22)~~

~~05. Restrictions -- Food Service Facility~~. ~~A symptomatic person excreting *Vibrio cholerae* must be managed under IDAPA 16.02.19, "Idaho Food Code."~~ ~~(3-17-22)~~

~~06. Restrictions -- Health Care Facility~~. ~~A person excreting *Vibrio cholerae* must not work in any occupation that provides personal care to persons confined in a health care or residential facility while in a communicable form, unless an exemption is obtained from the Department or Health District. A person in a health~~

~~care facility who has cholera must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules.~~ ~~(3-17-22)~~

~~**07. Restrictions - Household Contacts.**~~ A member of the household in which there is a case of cholera may not work in any occupations ~~listed~~ specified in ~~Subsections 200.04 through 200.06 of~~ this rule, unless approved by the Department or Health District. The household member must be asymptomatic and provide at least one (1) approved fecal specimen found to be negative on a culture by a licensed laboratory prior to being approved for work. ~~(3-17-22)~~( )

201. -- ~~209.~~ ~~(RESERVED)~~

~~210. CONGENITAL HYPOTHYROIDISM.~~

~~Each case or suspected case of congenital hypothyroidism must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~211. --~~ 219. (RESERVED)

220. CRYPTOSPORIDIOSIS.

~~**01. Reporting Requirements.** Each case of cryptosporidiosis must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~**02. Investigation.** Each reported case must be investigated to identify clusters or outbreaks of the infection, and identify the source of the infection.~~ ~~(3-17-22)~~

0~~3~~1. **Restrictions - Daycare Facility**. A fecally incontinent person excreting *Cryptosporidium* must not attend a daycare facility. A person excreting *Cryptosporidium* must not provide personal care in a daycare facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: (3-17-22)

a. At least two (2) successive fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or (3-17-22)

b. Diarrhea has ceased for twenty-four (24) hours. (3-17-22)

~~**04. Restrictions -- Food Service Facility.** A symptomatic person excreting *Cryptosporidium* is restricted from working as a food employee.~~ ~~(3-17-22)~~

0~~5~~2. **Restrictions - Health Care Facility**. A person excreting *Cryptosporidium* must not provide personal care in a custodial institution, or health care facility while fecally incontinent, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: (3-17-22)

a. At least two (2) successive fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or (3-17-22)

b. Diarrhea has ceased for twenty-four (24) hours. (3-17-22)

221. -- 229. (RESERVED)

230. DIPHTHERIA.

~~**01. Reporting Requirements.** Each case or suspected case of diphtheria must be reported to the Department or Health District immediately, at the time of identification, day or night.~~ ~~(3-17-22)~~

~~**02. Investigation and Response.** Each reported case of diphtheria must be investigated to determine if the illness is caused by a toxigenic strain of *Corynebacterium diphtheriae*, identify clusters or outbreaks of the infection, and identify contacts, carriers, and the source of the infection. Contacts of a person with toxigenic~~

~~diphtheria will be offered immunization against diphtheria.~~ ~~(3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of diphtheria.~~ ~~(3-17-22)~~

~~**04. Restrictions -- Daycare Facility**. A person diagnosed with diphtheria must be managed under Section 080 of these rules.~~ ~~(3-17-22)~~

0~~5~~1. **Restrictions - Health Care Facility**. (3-17-22)

a. A person with oropharyngeal toxigenic diphtheria in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," ~~as incorporated in Section 004 of these rules~~. The Department or Health District may withdraw this isolation requirement after two (2) cultures of the nose and two (2) cultures from the throat, taken at least twenty-four (24) hours apart and at least twenty-four (24) hours after the completion of antibiotic therapy, fail to show toxigenic *Corynebacterium diphtheriae* upon testing by a licensed laboratory.
~~(3-17-22)~~( )

b. A person with cutaneous toxigenic diphtheria must be placed under contact precautions. The Department or Health District may withdraw these precautions after two (2) cultures from the wound fail to show toxigenic *Corynebacterium diphtheriae* upon testing by a licensed laboratory. (3-17-22)

0~~6~~2. **Restrictions - Contacts**. Contacts of a person with toxigenic diphtheria are restricted from working as food employees, working in health care facilities, or from attending or working in daycare facilities or schools until they are determined not to be carriers by means of a nasopharyngeal culture or culture of other site suspected to be infected. These restrictions may be withdrawn by the Department or Health District. (3-17-22)

231. -- ~~**234. (RESERVED)**~~

~~**235. ECHINOCOCCOSIS.**~~

~~**01. Reporting Requirements**. Each case of echinococcosis must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of echinococcosis must be investigated to confirm the diagnosis and to identify possible sources of the infection.~~ ~~(3-17-22)~~

~~**236. -- 239. (RESERVED)**~~

~~**240. ENCEPHALITIS, VIRAL OR ASEPTIC.**~~

~~**01. Reporting Requirements**. Each case of viral or aseptic encephalitis, including meningoencephalitis, must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of viral or aseptic encephalitis meningoencephalitis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection.~~ ~~(3-17-22)~~

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

250. ESCHERICHIA COLI O157:H7 AND OTHER SHIGA-TOXIN PRODUCING E. COLI (STEC).

~~**01. Reporting Requirements**. Each case or suspected case of *Escherichia coli* O157:H7 or other Shiga-toxin producing *E. coli* (STEC) must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case must be investigated to determine if the person is employed as a~~

~~food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility. The investigation identifies clusters or outbreaks of the infection, and the most likely source of the infection.~~ ~~(3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day on any reported case of *E. coli* O157:H7 or other Shiga-toxin producing *E. coli* (STEC).~~ ~~(3-17-22)~~

041. Restrictions - Daycare Facility. A person who is excreting *E. coli* O157:H7 or other STEC must not attend daycare facilities while fecally incontinent or provide personal care to children in a daycare facility while the disease is present in a communicable form without the approval of the Department or Health District. Before returning to work or attendance at a daycare, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *E. coli* O157:H7 or other STEC. (3-17-22)

~~**05. Restrictions - Food Service Facility**. A person diagnosed with *E. coli* O157:H7 or other STEC must be managed under IDAPA 16.02.19, "Idaho Food Code."~~ ~~(3-17-22)~~

062. Restrictions - Health Care Facility. A person who is excreting *E. coli* O157:H7 or other STEC must not provide personal care to persons in a health care facility while the disease is present in a communicable form without the approval of the Department or Health District. Before returning to work, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *E. coli* O157:H7 or other STEC. (3-17-22)

251. --~~259.~~ ~~(RESERVED)~~

~~260. EXTRAORDINARY OCCURRENCE OF ILLNESS, INCLUDING CLUSTERS.~~

~~**01. Reporting Requirements**. Cases, suspected cases, and clusters of extraordinary or unusual illness must be reported to the Department or Health District within one (1) working day by the diagnosing person.~~ ~~(3-17-22)~~

~~**a.** Unusual outbreaks include illnesses that may be a significant risk to the public, may involve a large number of persons, or are a newly described entity.~~ ~~(3-17-22)~~

~~**b.** Even in the absence of a defined etiologic agent or toxic substance, clusters of unexplained acute illness and early-stage disease symptoms must be reported to the Department or Health District within one (1) working day and investigated.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of extraordinary occurrence of illness, including clusters, must be investigated to confirm the diagnosis, determine the extent of the cluster or outbreak, identify the source of infection or exposure, and determine whether there is a risk to the public warranting intervention by a public health agency. Evaluation and control measures will be undertaken in consultation with the Department and other appropriate agencies. The Department may elect to investigate by conducting special studies as outlined in Section 070 of these rules.~~ ~~(3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case.~~ ~~(3-17-22)~~

~~261. -- 269.~~ ~~(RESERVED)~~

~~270. FOOD POISONING, FOODBORNE ILLNESS, AND WATERBORNE ILLNESS.~~

~~**01. Reporting Requirements**. Each case, suspected case, or outbreak of food poisoning, foodborne illness, or waterborne illness must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case or outbreak of food poisoning, foodborne illness, or waterborne~~

~~illness must be investigated to confirm the diagnosis, determine the extent of transmission, identify the source, and determine if actions need to be taken to prevent additional cases.~~ ~~(3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day of any reported case or suspected case.~~ ~~(3-17-22)~~

~~**271. -- 279. (RESERVED)**~~

~~**280. GALACTOSEMIA.**~~
~~Each case or suspected case of galactosemia must be reported to the Department or Health District within one (1) working day after diagnosis.~~ ~~(3-17-22)~~

~~**281. --** 289. (RESERVED)~~

290. GIARDIASIS.

~~**01. Reporting Requirements**. Each case of giardiasis must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of giardiasis must be investigated to determine if the person is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility. The investigation identifies clusters or outbreaks of the infection, and the most likely source of the infection.~~ ~~(3-17-22)~~

0~~3~~1. **Restrictions - Daycare Facility**. A person with diarrhea who is excreting *Giardia lamblia* must not attend daycare while fecally incontinent or provide personal care to children in a daycare facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services or attend daycare with specific approval of the Department or Health District. (3-17-22)

~~**04. Restrictions -- Food Service Facility**. A symptomatic person who is excreting *Giardia lamblia* must be managed under IDAPA 16.02.19, "Idaho Food Code."~~ ~~(3-17-22)~~

0~~5~~2. **Restrictions - Health Care Facility**. A person with diarrhea who is excreting *Giardia lamblia* must not provide personal care to persons in a health care facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services with specific approval of the Department or Health District. (3-17-22)

291. -- ~~**299. (RESERVED)**~~

~~**300. HAEMOPHILUS INFLUENZAE INVASIVE DISEASE.**~~

~~**01. Reporting Requirements**. Each case or suspected case of *Haemophilus influenzae* invasive disease, including, but not limited to, meningitis, septicemia, bacteremia, epiglottitis, pneumonia, osteomyelitis and cellulitis, must be reported to the Department or Health District within one (1) working day of identification.~~
~~(3-17-22)~~

~~**02. Investigation**. Each reported case of *Haemophilus influenzae* invasive disease must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify contacts, and determine the need for antimicrobial prophylaxis of close contacts.~~ ~~(3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day on any reported case of *Haemophilus influenzae* invasive disease.~~ ~~(3-17-22)~~

~~**04. Restrictions -- Daycare Facility**. A person who is diagnosed with invasive disease caused by *Haemophilus influenzae* must not work in an occupation providing personal care to children, or attend a daycare facility as long as the disease is in a communicable form.~~ ~~(3-17-22)~~

05. Restrictions – School. A person who is diagnosed with invasive disease caused by *Haemophilus influenzae* must not work in any occupation where there is direct contact with students or attend a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)

301. – 309. (RESERVED)

310. HANTAVIRUS PULMONARY SYNDROME.

01. Reporting Requirements. Each case or suspected case of hantavirus pulmonary syndrome must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

02. Investigation. Each reported case of hantavirus pulmonary syndrome must be investigated to confirm the diagnosis, determine environmental risk factors leading to the infection, and determine any other at-risk individuals. (3-17-22)

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day by telephone on any reported case or suspected case of hantavirus pulmonary syndrome. (3-17-22)

311. – 319. (RESERVED)

320. HEMOLYTIC-UREMIC SYNDROME (HUS).

01. Reporting Requirements. Each case of hemolytic-uremic syndrome (HUS) or thrombotic thrombocytopenic purpura-HUS (TTP-HUS) must be reported to the Department or Health District within one (1) working day. (3-17-22)

02. Investigation. Each case of HUS or TTP-HUS must be investigated to confirm the diagnosis, determine the etiologic agent including *E. coli* O157:H7, non-O157 Shiga toxin producing *E. coli*, or other enteric pathogens, and determine the source of infection. (3-17-22)

321. – 329. (RESERVED)

330. HEPATITIS A.

01. Reporting Requirements. Each case or suspected case of hepatitis A must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

02. Investigation. Each reported case of hepatitis A must be investigated to confirm the diagnosis, identify contacts, determine the need for immune serum globulin (gamma globulin) or vaccine, and identify possible sources of the infection. (3-17-22)

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis A when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. (3-17-22)

04. Restrictions – Daycare Facility. A child who has hepatitis A must not attend a daycare facility until the disease is no longer communicable as determined by a licensed physician, or unless an exemption is made by the Department or Health District. (3-17-22)

a. A person with hepatitis A must not work in any occupation in which personal care is provided to children in a daycare facility while the disease is in a communicable form. (3-17-22)

b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form. (3-17-22)

05. Exclusion – Food Service Facility. (3-17-22)

~~a. A food employee with hepatitis A must be managed under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)~~

~~b. A specific test for recent hepatitis A infection (IgM antiHAV) must be performed by a licensed laboratory on all food employees suspected of having hepatitis A. (3-17-22)~~

~~06. Restrictions -- Health Care Facility. A person with hepatitis A in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. (3-17-22)~~

~~a. A person with hepatitis A must not work in any occupation in which personal care is provided to persons who are in a health care facility or living in a residential care facility while the disease is in a communicable form. (3-17-22)~~

~~b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form. (3-17-22)~~

0~~7~~1. **Restrictions - Household Contacts**. Any unvaccinated household member where there is a case of hepatitis A must not work in any of the occupations listed in ~~Subsections 330.04 through 330.06 of this rule~~ this Section, unless an exemption is obtained from the Department or Health District. ~~(3-17-22)~~( )

331. -- 339. (RESERVED)

340. HEPATITIS B.

~~01. Reporting Requirements. Each case or suspected case of hepatitis B must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

0~~2~~1. **Investigation**. Each reported case of hepatitis B must be investigated to confirm the diagnosis, identify contacts and carriers, determine the need for prophylaxis with immune globulins, determine the need for hepatitis B vaccine, determine the exposure of any pregnant women, and identify possible sources of the infection. (3-17-22)

~~03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis B when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. (3-17-22)~~

0~~4~~2. **Carrier Status**. The carrier status of a person diagnosed with hepatitis B will be determined six (6) months after the initial diagnosis is established. (3-17-22)

~~a. The carrier status will be determined by the presence of hepatitis B surface antigen (HBsAG) in blood obtained at least six (6) months after the initial diagnosis of hepatitis B. (3-17-22)~~

~~b. The test for hepatitis B surface antigen (HBsAg) must be performed by a licensed laboratory. (3-17-22)~~

~~c~~a. A person who is a carrier of hepatitis B must be reported to the Department or Health District by the physician at the time of determination for inclusion in the hepatitis B carrier registry. (3-17-22)

341. -- ~~349.~~ ~~(RESERVED)~~

~~350. HEPATITIS C.~~

~~01. Reporting Requirements. Each case of hepatitis C must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of hepatitis C must be investigated to confirm the diagnosis and identify possible sources of the infection. Hepatitis C may be confirmed by presence of hepatitis C antibody or antigen.~~ ~~(3-17-22)~~

~~03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis C when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services.~~ ~~(3-17-22)~~

~~351. —~~ 359. (RESERVED)

360. HUMAN IMMUNODEFICIENCY VIRUS (HIV).

01. Reporting Requirements. Each case of HIV infection, including clinical diagnosis, positive HIV laboratory tests for HIV antibody, HIV antigen (protein or nucleic acid), human immunodeficiency virus isolations, or other tests of infectiousness that indicate HIV infection, must be reported to the Department or Health District within three (3) working days of identification. ~~(3-17-22)~~( )

~~02. Investigation. Each reported case of HIV infection must be investigated to obtain specific clinical information, identify possible sources, risk factors, and contacts. Other manifestations of HIV infection as defined by the Centers for Disease Control and Prevention may be investigated.~~ ~~(3-17-22)~~

~~03. Testing Without an Informed Consent. A physician may order blood tests for HIV when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services.~~ ~~(3-17-22)~~

361. -- ~~369.~~ ~~(RESERVED)~~

~~370. HUMAN T-LYMPHOTROPIC VIRUS.~~

~~01. Reporting Requirements. Each case of HTLV infection must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation. Each reported case of HTLV infection must be investigated to determine the source of infection and evaluate risk factors.~~ ~~(3-17-22)~~

~~371. —~~ 379. (RESERVED)

380. LEAD POISONING.

01. Reporting Requirements. Each case of lead poisoning must be reported to the Department or Health District within three (3) working days of the identification of the case when determined by symptoms or a blood level of: (3-17-22)

a. Ten (10) micrograms or more per deciliter (10 ug/dL) of blood in adults eighteen (18) years and older; or (3-17-22)

b. ~~Five (5)~~ Three and a half (3.5) micrograms or more per deciliter (3.5 ug/dL) of blood in children under eighteen (18) years of age. (3-17-22)

~~02. Investigation. Each reported case of lead poisoning or excess lead exposure may be investigated to confirm blood lead levels, determine the source, and whether actions need to be taken to prevent additional cases.~~ ~~(3-17-22)~~

381. -- ~~389.~~ ~~(RESERVED)~~

~~390. LEGIONELLOSIS.~~

~~**01. Reporting Requirements**. Each case of legionellosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of legionellosis must be investigated to confirm the diagnosis and identify possible sources of the infection. When two (2) or more cases occur within thirty (30) days of each other, an investigation must be conducted to identify a common environmental source and identify ways to prevent further infections. (3-17-22)~~

~~**391. –**~~**399. (RESERVED)**

400. LEPROSY (HANSEN'S DISEASE).

~~**01. Reporting Requirements**. Each case of leprosy must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of leprosy must be investigated to confirm the diagnosis and to identify household or other close contacts. (3-17-22)~~

~~**03. Restrictions – Examination of Contacts**.~~ All household members or close contacts of a new case ~~must be examined~~ should be recommended to receive evaluation by a licensed physician for signs of leprosy~~. Household members and close contacts and persons in remission must be registered with the Department and undergo periodic medical examinations every six (6) to twelve (12) months for five (5) years~~ and consideration of chemoprophylaxis. ~~(3-17-22)~~( )

401. -- ~~**409. (RESERVED)**~~

~~**410. LEPTOSPIROSIS.**~~

~~**01. Reporting Requirements**. Each case of leptospirosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of leptospirosis must be investigated to confirm the diagnosis and to identify possible sources of the infection. (3-17-22)~~

~~**03. Handling of Report**. Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. (3-17-22)~~

~~**411. – 419. (RESERVED)**~~

~~**420. LISTERIOSIS.**~~

~~**01. Reporting Requirements**. Each case of listeriosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of listeriosis must be investigated to confirm the diagnosis and to identify possible sources of the infection and extent of the outbreak. (3-17-22)~~

~~**421. – 429. (RESERVED)**~~

~~**430. LYME DISEASE.**~~

~~**01. Reporting Requirements**. Each case of Lyme disease must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of Lyme disease must be investigated to confirm the diagnosis and to identify possible sources of the infection. (3-17-22)~~

~~03. Handling of Report. Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. (3-17-22)~~

~~431. -- 439. (RESERVED)~~

~~440. MALARIA.~~

~~01. Reporting Requirements. Each case of malaria must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of malaria must be investigated to determine the type and the source of the infection. If transmission may have occurred in Idaho, an entomologic investigation will be performed by the Department or Health District to determine the extent of mosquito activity, and to institute control measures if endemic transmission is determined. (3-17-22)~~

~~03. Testing Without an Informed Consent. A physician may order blood tests for malaria when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. (3-17-22)~~

~~441. -- 449. (RESERVED)~~

~~450. MAPLE SYRUP URINE DISEASE.~~
~~Each case or suspected case of maple syrup urine disease must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~451. --~~ 459. (RESERVED)

460. MEASLES (RUBEOLA).

~~01. Reporting Requirements. Each case or suspected case of measles must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~02. Investigation. Each reported case of measles must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify the source of the infection, and to identify susceptible contacts. (3-17-22)~~

~~03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of measles. (3-17-22)~~

041. **Restrictions - Daycare Facility and School**. (3-17-22)

a. A child diagnosed with measles must not attend a daycare facility or school as long as the disease is in a communicable form. (3-17-22)

b. In the event of a case of measles in a daycare or school, susceptible children must be excluded until adequate immunization is obtained, or the threat of further spread of the disease is contained, as provided in Sections 33-512(7) and 39-1118, Idaho Code. (3-17-22)

c. A person who is diagnosed as having measles must not work in any occupation in which there is direct contact with children, as long as the disease is in a communicable form. (3-17-22)

~~05. Restrictions -- Health Care Facility. A person diagnosed with measles in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated by reference in Section 004 of these rules. (3-17-22)~~

461. -- ~~469.~~ ~~(RESERVED)~~

~~470. MENINGITIS, VIRAL OR ASEPTIC.~~

~~01. Reporting Requirements. Each case of viral or aseptic meningitis must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation. Each reported case of viral or aseptic meningitis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection.~~ ~~(3-17-22)~~

~~471. –~~ 474. (RESERVED)

475. METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA).

01. Reporting Requirements. Each case or suspected case of invasive methicillin-resistant *Staphylococcus aureus* (MRSA), defined as MRSA isolated from a normally sterile site, must be reported to the Department or Health District within three (3) working days of identification by the laboratory director. (3-17-22)

~~02. Investigation. Any case of MRSA may be investigated to determine source and recommend measures to prevent spread.~~ ~~(3-17-22)~~

0~~3~~2. Restrictions - Daycare Facility. A person who is diagnosed with MRSA infection must not work in an occupation providing personal care to children, or attend a daycare facility, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and (3-17-22)

a. The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or (3-17-22)

b. The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. (3-17-22)

~~04. Restrictions – Food Service Facility. A food employee diagnosed with MRSA infection must be managed under IDAPA 16.02.19, "Idaho Food Code."~~ ~~(3-17-22)~~

0~~5~~3. Restrictions - Health Care Facility. A person who is diagnosed with MRSA infection must not provide personal care to persons in a health care facility if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and (3-17-22)

a. The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or (3-17-22)

b. The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. (3-17-22)

0~~6~~4. Restrictions - School. A person who is diagnosed with MRSA infection must not work in an occupation where there is direct contact with students or attend a private, parochial, charter, or public school, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and (3-17-22)

a. The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or (3-17-22)

b. The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. (3-17-22)

476. ~~–~~ ~~479.~~ ~~(RESERVED)~~

~~480. MUMPS.~~

~~01. Reporting Requirements. Each case of mumps must be reported to the Department or Health~~

District within three (3) working days of identification. (3-17-22)

02. Investigation. Each reported case of mumps must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify the source of the infection, and to identify susceptible contacts. (3-17-22)

03. Restrictions. A person with mumps must be restricted from daycare, school, or work for five (5) days after the onset of parotid swelling. (3-17-22)

481. -- 489. (RESERVED)

490. MYOCARDITIS, VIRAL.

01. Reporting Requirements. Each case of viral myocarditis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. Each reported case of viral myocarditis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. (3-17-22)

491. -- 499. (RESERVED)

500. NEISSERIA GONORRHOEAE.

01. Reporting Requirements. Each case of *Neisseria gonorrhoeae* infection must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)

02. Investigation. A person diagnosed with urethral, cervical, oropharyngeal, or rectal gonorrhea is required to inform all sexual contacts or provide sufficient information to health officials in order to locate these contacts. The contacts must be advised of their exposure to a sexually transmitted infection and informed they should seek examination and treatment. (3-17-22)

03. Prophylaxis of Newborns. Prophylaxis against gonococcal ophthalmia neonatorum is described in IDAPA 16.02.12, "Newborn Screening." (3-17-22)

04. Isolation -- Health Care Facility. A person with gonococcal ophthalmia neonatorum in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. (3-17-22)

501. -- 509. (RESERVED)

510. NEISSERIA MENINGITIDIS INVASIVE DISEASE.

01. Reporting Requirements. Each case or suspected case of *Neisseria meningitidis* invasive disease, including meningitis and septicemia, must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

02. Investigation. Each reported case of *Neisseria meningitidis* invasive disease must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify contacts, and determine the need for antimicrobial prophylaxis or immunization of close contacts. (3-17-22)

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of *Neisseria meningitidis* invasive disease. (3-17-22)

04. Restrictions -- Daycare Facility. A person who is diagnosed with a disease caused by *Neisseria meningitidis* must not provide personal care to children, or attend a daycare facility, as long as the disease is present in a communicable form. (3-17-22)

05. Restrictions - Health Care Facility. A person with *Neisseria meningitidis* in a health care facility or residential care facility must be placed under respiratory isolation until twenty-four (24) hours after initiation of effective therapy. (3-17-22)

06. Restrictions - School. A person who is diagnosed with a disease caused by *Neisseria meningitidis* must not work in any occupation that involves direct contact with students, or attend a private, parochial, charter, or public school as long as the disease is present in a communicable form. (3-17-22)

511. - 519. (RESERVED)

520. NOROVIRUS.

01. Reporting Requirements. Each case or suspected case of norovirus must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)

02. Investigation. Each reported case of norovirus must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. (3-17-22)

03. Restrictions - Daycare Facility. A person excreting norovirus must not attend or provide personal care in a daycare while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. (3-17-22)

04. Exclusions - Food Service Facility. A person suspected of infection with, or diagnosed with, norovirus is excluded from working as a food employee while symptomatic, unless an exemption is made by the Department or Health District. This exclusion will be withdrawn once the person is asymptomatic for at least twenty-four (24) hours. (3-17-22)

05. Restrictions - Health Care Facility. A person excreting norovirus must not provide personal care in a health care facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. (3-17-22)

06. Restrictions - School. A person excreting norovirus must not attend or work in a private, parochial, charter, or public school while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. (3-17-22)

521. (RESERVED)

522. NOVEL INFLUENZA A VIRUS.

01. Reporting Requirements. (3-17-22)

a. Each detection of a novel influenza A virus must be reported to the Department or Health District within one (1) working day of identification by the laboratory director. (3-17-22)

b. Each probable or confirmed case of a novel influenza A infection resulting in hospitalization must be reported to the Department or Health District within one (1) working day of the event. (3-17-22)

02. Investigation. Any case of a novel influenza A infection may be investigated to determine severity and recommend measures to prevent spread. (3-17-22)

03. Restrictions. A person diagnosed with novel influenza A virus infection must be restricted from daycare, school, or work for twenty-four (24) hours after the fever is resolved. Fever must be absent without the aid of fever reducing medicine. (3-17-22)

523. - 529. (RESERVED)

530. PERTUSSIS.

~~**01. Reporting Requirements**. Each case or suspected case of pertussis must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of pertussis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify susceptible contacts, and identify the source of the infection. (3-17-22)~~

~~**03. Restrictions – Daycare Facility**. A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. (3-17-22)~~

~~**04. Restrictions – Health Care Facility**. A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with other persons in a health care facility as long as the disease is in a communicable form. (3-17-22)~~

~~**05. Restrictions – School**. A person diagnosed with pertussis must not attend or work in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)~~

~~**531. – 539. (RESERVED)**~~

~~**540. PHENYLKETONURIA.**~~
~~Each case or suspected case of phenylketonuria must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~**541. –** 549. (RESERVED)

550. PLAGUE.

~~**01. Reporting Requirements**. Each case or suspected case of plague must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)~~

~~**02. Investigation**. Each reported case of plague must be investigated to confirm the diagnosis, determine the source, identify clusters or outbreaks of the infection, and whether there has been person-to-person transmission. (3-17-22)~~

~~**03. Handling of Report**. Each case of plague reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. (3-17-22)~~

~~**04. Restrictions – Daycare Facility**. A person who is diagnosed with pneumonic plague must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. (3-17-22)~~

~~**05. Restrictions – Health Care Facility**. (3-17-22)~~

~~**a.** A person with or suspected of having pneumonic plague in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. (3-17-22)~~

~~**b.** A person with or suspected of having bubonic plague in health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. (3-17-22)~~

~~**06. Restrictions – School**. A person diagnosed with pneumonic plague must not attend or work in any occupation in which there is direct contact with children, in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)~~

~~**07. Prophylaxis of Contacts.**~~ Household members and face-to-face contacts of a person with pneumonic plague must be ~~placed on~~ offered chemoprophylaxis and placed under surveillance for seven (7) days. A

person who refuses chemoprophylaxis must be maintained under ~~droplet precautions with careful~~ surveillance for seven (7) days. ~~(3-17-22)~~( )

551. -- ~~559.~~ ~~(RESERVED)~~

~~560. PNEUMOCOCCAL INVASIVE DISEASE IN CHILDREN LESS THAN EIGHTEEN YEARS OF AGE.~~

~~01. Reporting Requirements~~. ~~Each case of pneumococcal invasive disease in children under eighteen (18) years of age including, but not limited to, meningitis, septicemia, and bacteremia, must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of pneumococcal invasive disease in children must be investigated to confirm the diagnosis and determine relevant vaccine history.~~ ~~(3-17-22)~~

~~03. Restrictions – Daycare Facility~~. ~~A person who is diagnosed with pneumococcal invasive disease must not attend daycare or work in any occupation in which there is direct contact with children in a daycare facility as long as the disease is in a communicable form.~~ ~~(3-17-22)~~

~~04. Restrictions – School~~. ~~A person diagnosed with pneumococcal invasive disease must not attend or work in any occupation in which there is direct contact with children in a private, parochial, charter, or public school as long as the disease is in a communicable form.~~ ~~(3-17-22)~~

~~561. –~~ 569. (RESERVED)

570. PNEUMOCYSTIS PNEUMONIA (PCP).

~~01. Reporting Requirements~~. ~~Each case of *Pneumocystis* pneumonia (PCP) must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~–~~Each reported case of *Pneumocystis* pneumonia (PCP) must be investigated to confirm the diagnosis, and to determine ~~the underlying cause of any immune deficiency that may have~~ whether HIV contributed to the disease. ~~When the underlying cause is an HIV infection, it must be reported as described in Section 360 of these rules.~~ ~~(3-17-22)~~( )

571. -- 579. (RESERVED)

580. POLIOMYELITIS.

~~01. Reporting Requirements~~. ~~Each case or suspected case of poliomyelitis infection must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of poliomyelitis infection must be investigated to confirm the diagnosis, to determine whether the case is polio vaccine associated or wild virus associated, identify clusters or outbreaks of the infection, whether there has been person-to-person transmission, and to identify susceptible contacts, carriers, and source of the infection.~~ ~~(3-17-22)~~

~~03. Immunization of Personal Contacts~~. ~~–~~The immunization status of personal contacts ~~is~~ should be determined and susceptible contacts ~~are offered~~ recommended to receive immunization. ~~(3-17-22)~~( )

~~04. Restrictions – Daycare Facility~~. ~~A person who is diagnosed with poliomyelitis infection must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form.~~ ~~(3-17-22)~~

~~05. Restrictions – School.~~ ~~A person diagnosed with poliomyelitis infection must not attend or work in any occupation in which there is direct contact with children, in a private, parochial, charter, or public school as long as the disease is in a communicable form.~~ ~~(3-17-22)~~

581. ~~--589.~~ ~~(RESERVED)~~

~~590. PSITTACOSIS.~~

~~01. Reporting Requirements~~. ~~Each case of psittacosis must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify possible sources of the infection.~~ ~~(3-17-22)~~

~~03. Handling of Report~~. ~~Any identified sources or suspected sources of infection must be reported to the Department which will notify the Idaho Department of Agriculture if birds or other animals are involved.~~ ~~(3-17-22)~~

~~591. -- 599. (RESERVED)~~

~~600. Q FEVER.~~

~~01. Reporting Requirements~~. ~~Each case or suspected case of Q fever must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of Q fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection.~~ ~~(3-17-22)~~

~~03. Handling of Report~~. ~~Any identified or suspected sources of infection must be reported to the Department which will notify the Idaho Department of Agriculture if animals are involved.~~ ~~(3-17-22)~~

~~601. --~~ 609. (RESERVED)

610. RABIES - HUMAN, ANIMAL, AND POST-EXPOSURE PROPHYLAXIS (RPEP).

01. Reporting Requirements. (3-17-22)

~~a.~~ ~~Each case or suspected case of rabies in humans must be reported to the Department or Health District immediately, at the time of identification, day or night.~~ ~~(3-17-22)~~

~~b~~a. Each case of rabies in animals or rabies post-exposure prophylaxis series initiation in a human must be reported to the Department or Health District within one (1) working day of identification. ~~(3-17-22)~~( )

~~c.~~ ~~Each instance of rabies post-exposure prophylaxis (rPEP) series initiation must be reported to the Department or Health District within one (1) working day.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~(3-17-22)~~

~~a.~~ ~~Each reported case or suspected case of rabies in humans must be investigated to confirm the diagnosis, identify the source and other persons or animals that may have been exposed to the source, and identify persons who may need to undergo rPEP.~~ ~~(3-17-22)~~

b. Each suspected or confirmed case of rabies in animals will be investigated to determine if potential human or animal exposure has occurred and identify persons who may need to undergo rPEP. (3-17-22)

c. Each reported rPEP series initiation must be investigated to determine if additional individuals require rPEP and identify the source of possible rabies exposure. (3-17-22)

~~03. Handling of Report~~. ~~The Health District must notify the Department within one (1) working day of each reported case of this disease.~~ ~~(3-17-22)~~

042. Management of Exposure to Rabies. ~~All human exposures to a suspected or confirmed rabid animal must be managed as described under the guidelines presented in the "Human Rabies Prevention -- United States" incorporated by reference in Subsection 004.03 of these rules and "Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices" incorporated by reference in Subsection 004.07 in these rules. Animals involved with bites, or themselves bitten by a suspected or confirmed rabid animal, must be managed under the guidelines in the "Compendium of Animal Rabies Prevention and Control," incorporated by reference in Subsection 004.05 of these rules, and as described in Subsections 610.04.a., 610.04.b., and 610.04.c. of this rule.~~ In the event that a human or animal case of rabies occurs, any designated representative of the Department, Health District, or Idaho State Department of Agriculture, will establish such isolation and quarantine of animals involved as deemed necessary to protect the public health. ~~(3-17-22)~~( )

a. The management of a rabies-susceptible animal that has bitten or otherwise potentially exposed a person to rabies must be as follows: (3-17-22)

i. Any livestock that has bitten or otherwise potentially exposed a person to rabies will be referred to the Idaho State Department of Agriculture for management. (3-17-22)

ii. Any healthy domestic dog, cat, or ferret, regardless of rabies vaccination status, ~~that has bitten or otherwise potentially exposed a person to rabies must be confined and observed for illness daily for ten (10) days following the exposure~~ must be under the supervision of a licensed veterinarian or other person designated by the Idaho State Department of Agriculture, Health District, or the Department. ~~If signs suggestive of rabies develop, immediately consult the Health District or Department to discuss euthanasia and rabies testing.~~ ~~(3-17-22)~~( )

iii. Any domestic dog, cat, or ferret that cannot be managed as described in ~~Subsection 610.04.a.ii. of~~ this rule must be destroyed by a means other than shooting or other trauma ~~in~~ to the head. The head must be submitted to an approved laboratory for rabies analysis. ~~(3-17-22)~~( )

iv. It is the animal owner's responsibility to follow instructions provided for the management of the animal. (3-17-22)

v. Rabies susceptible animals other than domestic dogs, cats, or ferrets must be destroyed and the head submitted to an approved laboratory for rabies analysis, unless an exemption is given by the Department or Health District. (3-17-22)

vi. No person will destroy, or allow to be destroyed, the head of a rabies-susceptible animal that has bitten or otherwise potentially exposed a person to rabies without authorization from the Department or Health District. (3-17-22)

b. The management of a rabies-susceptible animal that has not bitten a person, but has been bitten, mouthed, mauled by, or closely confined in the same premises with a confirmed or suspected rabid animal must be as follows: (3-17-22)

i. Any exposed livestock will be referred to the Idaho State Department of Agriculture for management. (3-17-22)

ii. Any domestic dog, cat, or ferret that has never been vaccinated against rabies as recommended by the American Veterinary Medical Association, must be euthanized or appropriately vaccinated in accordance with guidance in the "Compendium of Animal Rabies Prevention and Control" ~~incorporated by reference in Subsection 004.05 of these rules as soon as possible and placed in strict quarantine for a period of four (4) months (six (6) months for ferrets)~~ and quarantined under the observation of a licensed veterinarian or a person designated by the Idaho State Department of Agriculture, Health District, or the Department. ~~The strict q~~ Quarantine of such an animal must be within an enclosure deemed adequate by a person designated by the Idaho State Department of Agriculture, Health District, or the Department ~~to prevent contact with any person or rabies-susceptible animal~~. If signs suggestive of rabies develop, the managing veterinarian or other designee must immediately consult the Health District or Department to discuss euthanasia or rabies testing. ~~Destruction of such an animal is permitted as an alternative to~~

~~strict quarantine.~~ ~~(3-17-22)~~( )

iii. An animal considered currently vaccinated against rabies, or overdue for rabies vaccination but with documentation of at least one (1) prior rabies vaccination, should be revaccinated against rabies as soon as possible with an appropriate vaccine, kept under the owner's control, and observed for illness for forty-five (45) days. If signs suggestive of rabies develop, the owner must immediately consult the Health District or Department to discuss euthanasia and rabies testing. These provisions apply only to animals for which an approved rabies vaccine is available. ~~Animals should be managed in accordance with guidance in the "Compendium of Animal Rabies Prevention and Control" incorporated by reference in Subsection 004.05 of these rules to conduct serological monitoring when a previous vaccination may have been received, but the documentation is unavailable. If evidence of previous vaccination cannot be demonstrated, the animal must be managed as described in Subsection 610.04.b.ii. of this rule.~~ ~~(3-17-22)~~( )

iv. The owner of the animal is financially responsible for the cost of managing and testing of the animal ~~as described in Subsection 610.04.b. of this rule~~. ~~(3-17-22)~~( )

c. Any rabies-susceptible animal other than domestic dogs, cats, ferrets, or livestock that are suspected of having rabies, or have been in close contact with an animal known to be rabid, must be ~~destroyed~~ euthanized, unless an exemption is granted by the Department or Health District. ( )

d. Any rabies susceptible animal other than domestic dogs, cats, ferrets, or other livestock that are suspected of having rabies, or have been in close contact with an animal known to be rabid, ~~The animal~~ must be euthanized and tested by an approved laboratory for rabies if a person has been bitten or has had direct contact with the animal that might result in the person becoming infected ~~unless an exemption is granted by the Department or Health District~~. ~~(3-17-22)~~( )

~~05. City or County Authority~~. ~~Nothing in these rules is intended or will be construed to limit the power of any city or county in its authority to enact more stringent requirements to prevent the transmission of rabies.~~ ~~(3-17-22)~~

611. ~~-- 619. (RESERVED)~~

~~620. RELAPSING FEVER, TICK-BORNE AND LOUSE-BORNE.~~

~~01. Reporting Requirements~~. ~~Each case of tick-borne or louse-borne relapsing fever must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of tick-borne or louse-borne relapsing fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and whether transmission was from lice or ticks.~~ ~~(3-17-22)~~

~~621. -- 629. (RESERVED)~~

~~630. RESPIRATORY SYNCYTIAL VIRUS (RSV).~~

~~A laboratory director must report each detection of respiratory syncytial virus (RSV) infection to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~631. -- 639. (RESERVED)~~

~~640. REYE SYNDROME.~~

~~01. Reporting Requirements~~. ~~Each case of Reye syndrome must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of Reye syndrome must be investigated to obtain specific clinical information and to learn more about the etiology, risk factors, and means of preventing the syndrome.~~ ~~(3-17-22)~~

~~**641. -- 649. (RESERVED)**~~

~~**650. ROCKY MOUNTAIN SPOTTED FEVER.**~~

~~**01. Reporting Requirements**. Each case of Rocky Mountain spotted fever must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of Rocky Mountain spotted fever must be investigated to confirm the diagnosis, identify the source of infection, and determine if control measures should be initiated. (3-17-22)~~

~~**651. --** 659. (RESERVED)~~

660. RUBELLA - INCLUDING CONGENITAL RUBELLA SYNDROME.

~~**01. Reporting Requirements**. Each case or suspected case of rubella or congenital rubella syndrome must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of rubella or congenital rubella syndrome must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify any contacts who are susceptible and pregnant, and document the presence of the congenital rubella syndrome. (3-17-22)~~

0~~3~~1. **Restrictions - Daycare Facility**. A person who is diagnosed with rubella must not attend daycare or work in any occupation in which there is close contact with children in a daycare facility as long as the disease is in a communicable form Infants with congenital rubella syndrome should be restricted from day care facilities until 2 clinical specimens obtained 1 month apart are negative for rubella virus. ~~(3-17-22)~~( )

~~**04. Restrictions -- Health Care Facility**. A person who is diagnosed with rubella must not work in any occupation in which there is close contact with other persons in a health care facility as long as the disease is in a communicable form. (3-17-22)~~

~~**05. Restrictions -- Schools**. A person who is diagnosed with rubella must not attend, be present, or work in any occupation in which there is close contact with children or other persons in a private, parochial, charter, or public school as long as the disease is in a communicable form. (3-17-22)~~

0~~6~~2. **Restrictions - Personal Contact**. A person who is diagnosed with rubella must not work in occupations in which there is close contact with women likely to be pregnant as long as the disease is in a communicable form. ~~(3-17-22)~~( )

661. -- 669. (RESERVED)

670. SALMONELLOSIS - INCLUDING TYPHOID FEVER.

~~**01. Reporting Requirements**. Each case or suspected case of salmonellosis or typhoid fever must be reported to the Department or Health District within one (1) working day of identification. (3-17-22)~~

~~**02. Investigation**. Each reported case of salmonellosis or typhoid fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and to identify contacts, carriers, and the source of infection. (3-17-22)~~

~~**03. Handling of Report**. The Department and the Health District will exchange reported information within one (1) working day on any suspected or reported case. (3-17-22)~~

0~~4~~1. **Restrictions - Chronic Carrier**. Chronic carriers, which are those who excrete *Salmonella* for more than one (1) year after onset, are restricted from working as food employees. Chronic carriers must not work in any occupation in which they provide personal care to children in daycare facilities, or to persons who are confined to

health care facilities or residential care facilities, until *Salmonella* is not identified by a licensed laboratory in any of three (3) successive approved fecal specimens collected at least seventy-two (72) hours apart. (3-17-22)

052. Restrictions - Non-Typhi Salmonella. (3-17-22)

a. A fecally incontinent person excreting non-Typhi *Salmonella* must not attend a daycare facility. (3-17-22)

b. A person excreting non-Typhi *Salmonella* must not work in any occupation in which they provide personal care to children in a daycare facility or provide personal care to persons confined to a health care facility, unless an exemption is obtained from the Department or Health District. (3-17-22)

c. A symptomatic food employee excreting non-Typhi *Salmonella* must be managed under the IDAPA 16.02.19, "Idaho Food Code." (3-17-22)

d. Before a person can attend or work in a daycare facility or a health care facility, or work as a food employee, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *Salmonella*. (3-17-22)

e. The Department may withdraw this restriction on a case of non-Typhi *Salmonella* provided that the person is asymptomatic. (3-17-22)

f. Any member of a household in which there is a case of non-Typhi salmonellosis must not work as a food employee until the member provides at least one (1) approved fecal specimen that fails to show *Salmonella* upon testing by a licensed laboratory. (3-17-22)

063. Restrictions - Salmonella Typhi. (3-17-22)

a. Any person with typhoid fever will remain subject to the supervision of the Department until *Salmonella Typhi* is not isolated by a licensed laboratory from three (3) successive approved fecal specimens collected at least twenty-four (24) hours apart ~~and not earlier than one (1) month after onset~~, and at least forty-eight (48) hours after the last dose of antibiotics. ~~(3-17-22)~~( )

~~**b.** A food employee excreting *Salmonella Typhi* must be managed under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)~~

eb. Any member of a household in which there is a case of *Salmonella Typhi* must not work in the occupations described in ~~Subsection 670.05.d. of this rule~~ this Section until the member provides at least two (2) successive approved fecal specimens collected twenty-four (24) hours apart that fail to show *Salmonella* upon testing by a licensed laboratory. ~~(3-17-22)~~( )

dc. All chronic carriers of *Salmonella Typhi* must abide by a written agreement called a typhoid fever carrier agreement. This agreement is between the chronic carrier and the Department or Health District. Failure of the carrier to abide by the carrier agreement may cause the carrier to be isolated under Section 065 of these rules. The carrier agreement requires: (3-17-22)

i. The carrier cannot work as a food employee; (3-17-22)

ii. Specimens must be furnished for examination in a manner described by the Department or Health District; and (3-17-22)

iii. The Department or Health District must be notified immediately of any change of address, occupation, and cases of illness suggestive of typhoid fever in their family or among immediate associates, while there is a chronic carrier under a typhoid fever carrier agreement. ~~(3-17-22)~~( )

ed. Chronic carriers of typhoid fever may be released from carrier status when *Salmonella Typhi* is not identified by a licensed laboratory in any of six (6) consecutive approved fecal and urine specimens collected at least

one (1) month apart. (3-17-22)

671. ~~--679.~~ ~~(RESERVED)~~

~~680. SEVERE ACUTE RESPIRATORY SYNDROME (SARS).~~

~~01. Reporting Requirements~~. ~~Each case or suspected case of severe acute respiratory syndrome (SARS) must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of SARS must be investigated to confirm the diagnosis, review the travel and other exposure history, identify other persons potentially at risk, and identify the most likely source of the infection.~~ ~~(3-17-22)~~

~~03. Isolation~~. ~~Recommendations for appropriate isolation of the suspected or confirmed case will be made by the Department or Health District.~~ ~~(3-17-22)~~

~~681. -- 689. (RESERVED)~~

~~690. SEVERE REACTION TO ANY IMMUNIZATION.~~

~~01. Reporting Requirements~~. ~~Each case or suspected case of a severe reaction to any immunization must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of severe reaction to any immunization must be investigated to confirm and document the circumstances relating to the reported reaction to the immunization.~~ ~~(3-17-22)~~

~~03. Handling of Report~~. ~~The Department and the Health District will exchange reported information within one (1) working day on any reported case.~~ ~~(3-17-22)~~

~~691. --~~ 699. (RESERVED)

700. SHIGELLOSIS.

~~01. Reporting Requirements~~. ~~Each case or suspected case of shigellosis must be reported to the Department or Health District within one (1) working day of identification.~~ ~~(3-17-22)~~

~~02. Investigation~~. ~~Each reported case of shigellosis must be investigated to confirm the diagnosis and identify clusters or outbreaks of the infection. An attempt must be made to identify contacts, carriers, and the source of the infection.~~ ~~(3-17-22)~~

~~03. Handling of Report~~. ~~The Department and the Health District will exchange reported information within one (1) working day on any suspected or reported case.~~ ~~(3-17-22)~~

04~~1~~. Restrictions - Daycare Facility. (3-17-22)

a. A person excreting *Shigella* must not attend a daycare facility while fecally incontinent. (3-17-22)

b. A person excreting *Shigella* must not work in any occupation in which they provide personal care to children in a daycare facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a daycare facility, a cohort system may be approved. (3-17-22)

c. The Department or Health District may withdraw the daycare restriction when the person has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. (3-17-22)

~~**05. Exclusions - Food Service Facility.** (3-17-22)~~

~~**a.** A food employee excreting *Shigella* must be managed under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)~~

~~**b.** The Department or Health District may withdraw the food service restriction when the employee has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. (3-17-22)~~

062. Restrictions - Health Care Facility. (3-17-22)

a. A person excreting *Shigella* must not work in any occupation in which they provide personal care to persons who are confined to a health care facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a facility, a cohort system may be approved. (3-17-22)

b. The Department or Health District may withdraw the health care facility restriction when the employee has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. (3-17-22)

c. During an outbreak in a facility, a cohort system may be approved. (3-17-22)

073. Restrictions - Household Contacts. No member of a household, in which there is a case of shigellosis, may work in any occupations in ~~Subsections 700.04 through 700.06 of this rule~~ this Section, unless the Department or Health District approves and at least one (1) approved fecal specimen is negative for *Shigella* upon testing by a licensed laboratory. ~~(3-17-22)~~( )

701. -- 709. (RESERVED)

710. SMALLPOX.

~~**01. Reporting Requirements.** Each case or suspected case of smallpox must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)~~

~~**02. Investigation.** Each reported case of smallpox must be investigated promptly to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection and susceptible contacts. (3-17-22)~~

~~**03. Restrictions - Daycare Facility.** (3-17-22)~~

~~**a.** A person diagnosed with smallpox must not attend a daycare facility as long as the disease is in a communicable form. (3-17-22)~~

~~**b.** In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from daycare facilities where a case has been identified until adequate immunization is obtained or the threat of further spread is contained. (3-17-22)~~

~~**04. Restrictions - Health Care Facility.** A person diagnosed or suspected of having smallpox in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. (3-17-22)~~

051. Restrictions - Public Gatherings. A person diagnosed with smallpox must not attend public gatherings as long as the disease is in a communicable form. (3-17-22)

~~**06. Restrictions - School.** (3-17-22)~~

~~**a.** A person diagnosed with smallpox, regardless of age, must not attend a private, parochial, charter,~~

~~or public school as long as the disease is in a communicable form.~~ ~~(3-17-22)~~

~~**b.** In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from schools where a case has been identified until adequate immunization is obtained or the threat of further spread is contained under Section 33-512(7), Idaho Code.~~ ~~(3-17-22)~~

0~~7~~2. **Restrictions - Working**. A person diagnosed with smallpox must not work in any occupation as long as the disease is in a communicable form. (3-17-22)

711. -- ~~**719.**~~ ~~**(RESERVED)**~~

~~**720. STREPTOCOCCUS PYOGENES (GROUP A STREP) INFECTIONS.**~~

~~**01. Reporting Requirements**. Each case of *Streptococcus pyogenes* (group A strep) infection that is invasive or results in rheumatic fever or necrotizing fasciitis must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of *Streptococcus pyogenes* (group A strep) infection that is invasive or results in rheumatic fever or necrotizing fasciitis must be investigated to confirm the diagnosis, to determine if the infection is part of an outbreak, and to identify the source of the infection.~~ ~~(3-17-22)~~

~~**03. Restrictions -- Daycare Facility**. An infected person must not attend or work in a daycare until twenty-four (24) hours has elapsed after treatment is initiated or until they are no longer infectious as determined by a physician, the Department, or Health District.~~ ~~(3-17-22)~~

~~**04. Restrictions -- Health Care Facility**. An infected person must not work in a health care facility until twenty-four (24) hours has elapsed after treatment is initiated or until they are no longer infectious as determined by a physician, the Department, or Health District.~~ ~~(3-17-22)~~

~~**05. Restrictions -- School**. An infected person must not attend or work in a private, parochial, charter, or public school until twenty-four (24) hours has elapsed after treatment is initiated or until the patient is no longer infectious as determined by a physician, the Department, or Health District.~~ ~~(3-17-22)~~

~~**721. -- 729. (RESERVED)**~~

~~**730. SYPHILIS.**~~

~~**01. Reporting Requirements**. Each case or suspected case of syphilis must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~**02. Investigation**. Each reported case of primary, secondary, or early latent syphilis must be investigated by the Department or Health District. Each person diagnosed with primary, secondary, or early latent infectious syphilis is required to inform all sexual contacts that they may have been exposed to a sexually transmitted infection, or provide sufficient information to public health officials so they may locate contacts and ensure that each is offered prompt diagnosis and treatment under Section 39-605, Idaho Code.~~ ~~(3-17-22)~~

~~**03. Testing Without an Informed Consent**. A physician may order blood tests for syphilis when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services.~~ ~~(3-17-22)~~

~~**731. -- 739. (RESERVED)**~~

~~**740. TETANUS.**~~

~~**01. Reporting Requirements**. Each case of tetanus must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-17-22)~~

~~02. Investigation. Each reported case of tetanus must be investigated to confirm the diagnosis and to determine the immunization status of the case. (3-17-22)~~

~~741. -- 749. (RESERVED)~~

~~750. TOXIC SHOCK SYNDROME.~~

~~01. Reporting Requirements. Each case of toxic shock syndrome must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of toxic shock syndrome must be investigated to obtain specific clinical information on the syndrome and to determine the etiology, risk factors, and means of preventing the syndrome. (3-17-22)~~

~~751. -- 759. (RESERVED)~~

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

~~01. Reporting Requirements. Each case or suspected case of transmissible spongiform encephalopathy (TSE), including Creutzfeldt-Jakob disease (CJD) and variant CJD (vCJD) must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of transmissible spongiform encephalopathy (TSE) must be investigated to determine the cause and confirm the diagnosis. (3-17-22)~~

~~03. Autopsy. The state epidemiologist may order an autopsy for suspected CJD or vCJD deaths as per Section 39-277, Idaho Code. (3-17-22)~~

~~761. -- 769. (RESERVED)~~

~~770. TRICHINOSIS.~~

~~01. Reporting Requirements. Each case of trichinosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of trichinosis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. (3-17-22)~~

~~03. Handling of Report. The Department will notify the Idaho Department of Agriculture and other regulatory agencies as applicable. (3-17-22)~~

~~771. --~~ 779. (RESERVED)

780. TUBERCULOSIS.

~~01. Reporting Requirements. Each case of tuberculosis must be reported to the Department or Health District within three (3) working days of identification. (3-17-22)~~

~~02. Investigation. Each reported case of tuberculosis must be investigated to confirm the diagnosis, identify contacts, associated cases, and the source of the infection. (3-17-22)~~

0~~3~~1. **Active Pulmonary Tuberculosis - Definition**. Tuberculosis disease of the lungs, determined by a physician to be potentially contagious by clinical or bacteriological evidence or by evidence of the spread of the disease to others. Tuberculosis is considered active until cured. (3-17-22)

0~~4~~2. **Cure of Tuberculosis - Definition**. The completion of a course of antituberculosis treatment.

(3-17-22)

~~**05. Restrictions - Daycare Facility**. A person with active pulmonary tuberculosis must not attend or work in any occupation in which they have direct contact or provides personal care to children in a daycare facility, until they are determined to be noninfectious by a licensed physician, the Department, or Health District. (3-17-22)~~

063. Restrictions - Health Care Facility. (3-17-22)

a. A person suspected to have pulmonary tuberculosis in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," ~~as incorporated in Section 004 of these rules,~~ until the diagnosis of active pulmonary tuberculosis is excluded by a licensed physician. ~~(3-17-22)~~( )

b. A person with active pulmonary tuberculosis in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," ~~as incorporated in Section 004 of these rules,~~ until they are determined to be noninfectious by a licensed physician, the infection control committee of the facility, or the Department. ~~(3-17-22)~~( )

c. A person with active pulmonary tuberculosis must not work in any occupation in which they have direct contact or provides personal care to persons confined to a health care or residential care facility, until they are determined to be noninfectious by a licensed physician, infection control committee of the facility, or the Department. (3-17-22)

d. In the event that active pulmonary tuberculosis is diagnosed in an employee, patient, or resident, the health care facility must conduct an investigation to identify contacts. The Department or Health District may assist in the investigation. (3-17-22)

074. Restrictions - School. A person with active pulmonary tuberculosis must not attend or work in any occupation in which they have direct contact with students in a private, parochial, charter, or public school until they are determined to be noninfectious by a licensed physician, the Department, or Health District. (3-17-22)

085. Restrictions - Household Contacts. Any member of a household, in which there is a case of active pulmonary tuberculosis, must not attend or work in any occupation in which they provide direct supervision of students in a school, personal care to children in a daycare facility or persons confined to a health care facility, or works in a food service facility, until they have been determined to be noninfectious by a licensed physician, the Department, or Health District. (3-17-22)

781. -- ~~**789. (RESERVED)**~~

~~**790. TULAREMIA.**~~

~~**01. Reporting Requirements**. Each case or suspected case of tularemia must be reported to the Department or Health District immediately, at the time of identification, day or night. (3-17-22)~~

~~**02. Investigation**. Each reported case of tularemia must be investigated to confirm the diagnosis and to identify the source of the infection. (3-17-22)~~

~~**03. Handling of Report**. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the infection. (3-17-22)~~

~~**791. -- 809. (RESERVED)**~~

~~**810. YERSINIOSIS, OTHER THAN PLAGUE.**~~

~~**01. Reporting Requirements**. Each case of yersiniosis, other than plague, must be reported to the Department or Health District within three (3) working days of identification. Plague must be reported immediately as described in Section 550 of these rules. (3-17-22)~~

~~**02. Investigation**. Each reported case of yersiniosis must be investigated to confirm the diagnosis, identify carriers, and the source of the infection. (3-17-22)~~

~~**03. Restrictions -- Food Service Facility**. A symptomatic person must be managed under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)~~

~~**811. -- 949. (RESERVED)**~~

~~**DELEGATION OF POWERS AND DUTIES
(Sections 950-999)**~~

~~**950. DELEGATION OF POWERS AND DUTIES.**~~
~~The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by both the Director and the Health District Board. (3-17-22)~~

~~**951. --** 999. (RESERVED)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.27 – IDAHO RADIATION CONTROL RULES

DOCKET NO. 16-0227-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 56-1003, Idaho Code, and 56-1007, 56-1041, 56-1043, 56-1044, and 56-1046.

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

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, June 11, 2025 **9:00 AM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m01fcd4491a48a596c81df58ce05f195c** **Join by meeting number** **Meeting number (access code): 2830 144 4738** **Meeting password: bMyb9qWJM33** **Meeting password when dialing from a phone or video system: 26929795** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Tuesday, June 17, 2025 **2:00 PM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mda6f340678aa8ccb36168bac6c83bfe0** **Join by meeting number** **Meeting number (access code): 2819 064 2981** **Meeting password: WmWTKTPQ236** **Meeting password when dialing from a phone or video system: 96985877** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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

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

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

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

Fees will not be increased as a result of this rulemaking.

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

There is not anticipated to be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, Volume 25-4, pages 19 and 20.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25th, 2025.

DATED this 2nd day of May, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone
(208) 334-6558 fax
DHWRules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0227-2501
(ZBR Chapter Rewrite)

16.02.27 – IDAHO RADIATION CONTROL RULES

000. LEGAL AUTHORITY.
~~The Idaho Legislature, under the following Sections of statute has granted authority to the Board of Health and Welfare and the Director of the Department to adopt rules related to x-ray producing machines in order to protect the health of the people of Idaho. Sections 56-1041 and 56-1043, Idaho Code, grant authority to the Board of Health and Welfare to adopt radiation control rules. Section 56-1041, Idaho Code, establishes the Department as the designated agency to regulate, license, and control radiation associated with x-ray machines. Section 56-1044, Idaho Code, requires that radiation machines for mammography be registered with the Department, as provided in rule. Section 56-1046, Idaho Code, grants authority to the Department to establish record-keeping and reporting requirements for those who possess or use an x-ray machine. Section 56-1003, Idaho Code, grants authority to the Director to supervise and administer laboratories. Section 56-1007, grants authority to the Department to charge and collect fees established by rule~~This chapter is adopted under the legal authority of Sections 56-1003, 56-1007, 56-1041, 56-1043, 56-1044, and 56-1046, Idaho Code. ~~(3-15-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~**01. Title**. These rules are titled IDAPA 16.02.27, "Idaho Radiation Control Rules." (3-15-22)~~

~~**02. Scope**. Except as otherwise specifically provided, these rules apply to all persons who possess, use, transfer, own, or acquire any radiation machine~~To define licensure, education, quality assurance, and safety requirements for X-ray machines. ~~(3-15-22)~~( )

~~**002. – 003. (RESERVED)**~~

~~**004. INCORPORATION BY REFERENCE.**~~
~~The documents referenced in Subsections 004.01 through 004.03 of this rule are used as a means of further clarifying these rules. These documents are incorporated by reference and are available online as provided, or may be reviewed at the Department of Health and Welfare, Idaho Bureau of Laboratories at 2220 Old Penitentiary Road, Boise, Idaho 83712-8299. (3-15-22)~~

~~**01. National Council of Radiation Protection (NCRP) Report No. 147**. National Council of Radiation Protection (NCRP) Report No. 147, entitled: "Structural Shielding Design and Evaluation for Medical Use of X-rays and Gamma Rays of Energies up to Ten (10) MeV," issued November 19, 2004, by the National Council on Radiation Protection and Measurement. This document may be obtained from: NCRP Publications, 7910 Woodmont, Bethesda, MD 20814, e-mail: NCRPpubs@NCRPonline.org, phone: 1-301-657-2652, Ext. 14. (3-15-22)~~

~~**02. Mammography Quality Standards Act Regulations, Part 900**. The Mammography Quality Standards Act Regulations, Part 900, located at 21 CFR 900.12 as authorized by 21 U.S.C. 360i, 360nn, 374(e); and 42 U.S.C. 263b. A copy of these regulation may be ordered from the U.S. Food and Drug Administration, 10903 New Hampshire Avenue, Silver Spring, MD 20993, phone: 1-888-INFO-FDA (1-888-463-6332). These regulations are available online at http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/ucm110906.htm#s9001. (3-15-22)~~

~~**03. Suggested State Regulations for Control of Radiation, Volume 1**. This publication is being adopted with the exclusions, modifications, and additions listed below in Subsections 004.03.a through 004.03.k of this rule. Suggested State Regulations for Control of Radiation, Volume 1, is published by the Conference of Radiation Control Program Directors, Inc., 1030 Burlington Lane, Suite 4B, Frankfort, Kentucky 40601. It is also available online at https://www.crcpd.org/page/SSRCRs. (3-15-22)~~

~~a. Part A -- General Provisions (March 2003). Modifications have been made to this Part. See Sections 100 - 199 of these rules. (3-15-22)~~

~~b. Part B -- Registration [Licensure] of Radiation Machine Facilities, [Services] And Associated Healthcare Professionals (February 2009). Exclusions and modifications have been made to this Part. See Sections 200 - 299 of these rules. (3-15-22)~~

~~c. Part C -- Licensing of Radioactive Material (March 2010). This Part is excluded from incorporation. (3-15-22)~~

~~d. Part D -- Standards for Protection Against Radiation (March 2003). The following Sections of this Part are incorporated: 1101a, 1101b, 1101c, 1201a, 1201b, 1201c, 1201f, 1206, 1207, 1208, 1301, 1501, 1502, 1503, 1601, 1602, 1901, 1902, 1903, 1904c, 2102, 2103a, 2104, 2105, 2106, 2107a, 2110, 2201, 2202, 2203, 2204, 2205, and 2207b. (3-15-22)~~

~~e. Part E -- Radiation Safety Requirements for Industrial Radiographic Operations (February 1999). Exclusions have been made to this Part. See Sections 400 - 499 of these rules. (3-15-22)~~

~~f. Part F -- Diagnostic X-rays and Imaging Systems in the Healing Arts (May 2009). This Part is incorporated with no exclusions, modifications, or additions. (3-15-22)~~

~~g. Part G -- Use of Radionuclides in the Healing Arts (March 2003). This Part is excluded from incorporation. (3-15-22)~~

~~h. Part H -- Radiation Safety Requirements for Analytical X-ray Equipment (January 1991). This Part is incorporated with no exclusions, modifications, or additions. (3-15-22)~~

~~i. Part I -- Radiation Safety Requirements For Particle Accelerators (January 1991). This Part is excluded from incorporation. (3-15-22)~~

~~j. Part J -- Notices, Instructions and Reports to Workers; Inspections (March 2003). This Part is incorporated with no exclusions, modifications, or additions. (3-15-22)~~

~~k. Parts M through Z. These Parts are excluded from incorporation. (3-15-22)~~

~~**005. -- 049. (RESERVED)**~~

~~**050. LICENSING.**~~
~~Sections 050 through 099 of these rules provide for the licensing of radiation machines. (3-15-22)~~

~~**051. MACHINES REQUIRED TO BE LICENSED.**~~
~~Radiation producing machines, unless exempt under Section B.4 of the Suggested State Regulations for Control of Radiation incorporated under Section 004 of these rules, must be licensed with the Radiation Control Agency in accordance with the requirements of Sections B.6 through B.9, of the Suggested State Regulations for Control of Radiation, as applicable. (3-15-22)~~

~~**052. FEES.**~~

~~**01. Radiation Licensing Fees**. Radiation facility fees apply to each person or facility owning, leasing, storing, or using radiation-producing machines. This fee is assessed on the same cycle as inspections and consists of a base licensing fee and a per tube charge. Fees are due within thirty (30) calendar days of the renewal date. A late charge of fifty ($50) dollars will be assessed at thirty one (31) days past the renewal date. If the fees are not paid by day ninety-one (91) past the renewal date, licensure will be terminated.~~

X-Ray Renewal Cycle and Facility Fees			
Facility Type	Renewal Cycle	Facility Fee	Per Tube Fee
Hospital, Clinic, Medical Practice	2 Years	$50	$25
Dental, Chiropractic, Podiatric, Veterinary Practice	4 Years	$50	$25
Industrial, research, academic/ educational, or security	10 Years	$50	$25

(3-15-22)

02. X-Ray Shielding Plan Review and Fee. Facilities housing X-ray producing devices and regulated under these rules must obtain a review of their shielding plan by a qualified expert. A copy of this review, to include a floor plan and site specific shielding calculations, must be submitted to the Radiation Control Agency within thirty (30) days of receipt. Facilities may request a departmental review of the X-ray shielding calculations and floor plan by the Radiation Control Agency. A three hundred fifty dollar ($350) fee will be charged for this service. (3-15-22)

03. Radiation Safety Program Fee. If a facility or group of facilities under one administrative control employs one (1) or more full time individuals whose positions are entirely devoted to in house radiation safety, the facility may pay a flat annual facility fee of one thousand dollars ($1,000) instead of the licensing fees required in Subsection 052.01 of this rule. In addition, annual submittal of documentation of evidence of an ongoing and functioning quality control program must be submitted for review and approval. (3-15-22)

053. APPLICATION FOR LICENSE.
In addition to the requirements detailed in the incorporated reference, Section B, the following is required with application for use of x-ray producing devices. (3-15-22)

01. Responsible Authority. All applications must be signed by the responsible authority (RA) over the x-ray producing device. Required qualifications of the RA can be found in Section B.6c of the SSRCR. (3-15-22)

02. Application For License. Application for license must be on forms furnished by the Radiation Control Agency and must contain: (3-15-22)

a. Name of the owner, organization or person having administrative control and responsibility for use (responsible authority); and (3-15-22)

b. Address and telephone number where the machine is located; and if the radiation producing machine is used as a mobile device, a central headquarters must be used. (3-15-22)

c. A designation of the general category of use, such as dental, medical, industrial, veterinary, and research; and (3-15-22)

d. The manufacturer, model number, and type of machine; and (3-15-22)

e. Name of the radiation machine supplier, installer, and service agent. (3-15-22)

f. Name of an individual to be responsible for radiation protection, when applicable. (3-15-22)

03. Qualifications for Authorized Operation, Service, and Repair of X-ray Machines. The responsible authority must prohibit any person from operating, performing maintenance, or furnishing servicing or services to an x-ray producing machine under their authority that is not properly trained, certified, or licensed to do so. The responsible authority must obtain and retain documentation for a minimum of two (2) years that all operation, service, repair, and maintenance of x-ray producing machine(s) under their authority are done so by a qualified

individual or entity. (3-15-22)

04. Operator Qualifications. No individual will be permitted to act as an operator of a particular machine until such individual has received an acceptable amount of training in radiation safety as it applies to that machine and is approved by the Radiation Protection Supervisor or Radiation Safety Officer. Operators will be responsible for: (3-15-22)

a. Keeping radiation exposure to himself and to others as low as is practical; (3-15-22)

b. Being familiar with safety procedures as they apply to each machine; (3-15-22)

c. Wearing of personnel monitoring devices, if applicable; and (3-15-22)

d. Notifying the Radiation Protection Supervisor or Radiation Safety Officer of known or suspected excessive radiation exposures to himself or others. (3-15-22)

05. Minimum Safety Requirements. Unless otherwise specified within these or the incorporated rules, the following are the minimum safety requirements for personnel acting as radiographers or radiographers assistants. (3-15-22)

a. Licensees must not permit any individuals to act as radiographers as defined in these rules until such individuals: (3-15-22)

i. Have received copies of and instructions in the licensee's operating and emergency procedures; and have demonstrated understanding thereof; and (3-15-22)

ii. Have been instructed in the subjects outlined in Subsection 053.06 of this rule, and have demonstrated understanding thereof; and (3-15-22)

iii. Have received copies of and instruction in the correct execution of these rules and have demonstrated understanding thereof; and (3-15-22)

iv. Have demonstrated competence to use the specific radiation machine(s), related handling tools, and survey instruments that will be employed in their assignment. (3-15-22)

v. Have demonstrated an understanding of the instructions in this section by successful completion of a written test and a field examination on the subjects covered. (3-15-22)

b. Licensees must not permit any individuals to act as a radiographer's assistant as defined in these rules until such individuals: (3-15-22)

vi. Have received copies of and instructions in the licensee's operating and emergency procedures; and have demonstrated understanding thereof; and (3-15-22)

vii. Have demonstrated competence to use under the personal supervision of the radiographer the radiation machine(s) and radiation survey instrument(s) that will be employed in their assignment. (3-15-22)

viii. Have demonstrated an understanding of the instructions in this section by successfully completing a written or oral test and a field examination on the subjects covered. (3-15-22)

c. Records of the above training, including copies of written tests and dates of oral tests and field examinations, must be maintained for inspection by the Radiation Control Agency for three (3) years following termination of employment. (3-15-22)

d. Each licensee must conduct an internal audit program to ensure that the Radiation Control Agency's conditions and the licensee's operating and emergency procedures are followed by each radiographer and radiographer's assistant. These internal audits must be performed at least quarterly, and each radiographer must be

audited at least annually. Records of internal audits must be maintained for inspection by the Agency for two (2) years from the date of the audit. (3-15-22)

06. Subjects to Be Covered During the Instruction of Radiographers. (3-15-22)

a. Fundamentals of Radiation Safety, to include at least: (3-15-22)

i. Characteristics of gamma and x-radiation; (3-15-22)

ii. Units of radiation dose (millirem); (3-15-22)

iii. Bioeffects of excessive exposure of radiation; (3-15-22)

iv. Levels of radiation from radiation machines; (3-15-22)

v. Methods of controlling radiation dose, including: (3-15-22)

(1) Working time; (3-15-22)

(2) Working distances; and (3-15-22)

(3) Shielding; (3-15-22)

vi. Radiation Protection Standards; (3-15-22)

b. Radiation Detection Instrumentation, to include at least: (3-15-22)

i. Use of radiation surveys instruments, including: (3-15-22)

(1) Operation; (3-15-22)

(2) Calibration; and (3-15-22)

(3) Limitations; (3-15-22)

ii. Survey techniques; (3-15-22)

iii. Use of Personnel Monitoring Equipment, including: (3-15-22)

(1) Film badges, TLDs; (3-15-22)

(2) Pocket dosimeters; and (3-15-22)

(3) Pocket chambers; (3-15-22)

c. Radiographic Equipment, to include operation and control of x-ray equipment; (3-15-22)

d. The Requirements of Pertinent Federal regulations and State rules; (3-15-22)

e. The Licensee's Written Operating and Emergency Procedures; and (3-15-22)

f. Case histories of radiography accidents. (3-15-22)

07. Modification, Revocation, and Termination of Licenses. In accordance with amendments to the Act, departmental rules or regulations, or orders issued by the Radiation Control Agency, the terms and conditions of all licenses are subject to amendment, revision, or modification, and are subject to suspension or revocation. (3-15-22)

a. Any license can be revoked, suspended, modified, or denied, in whole or in part. (3-15-22)

i. For any materially false statement: (3-15-22)

(1) In the application; or (3-15-22)

(2) In any statement of fact required under provisions of the Act or under these rules; or (3-15-22)

ii. Because of conditions revealed: (3-15-22)

(1) Within the application; any report, record, or inspection; or (3-15-22)

(2) By any other means that would warrant the Radiation Control Agency to refuse to grant a license on an original application; or (3-15-22)

iii. For violations of or failure to observe any of the terms and conditions: (3-15-22)

(1) Of the Act; or (3-15-22)

(2) Of the license; or (3-15-22)

(3) Of any rule; or (3-15-22)

(4) Of any regulation; or (3-15-22)

(5) Of an order of the Radiation Control Agency. (3-15-22)

b. Except in cases of willful violation or in which the public health, interest or safety requires otherwise, no license can be modified, suspended, or revoked unless such issues have been called to the attention of the licensee in writing and the licensee afforded the opportunity to demonstrate or achieve compliance with all lawful requirements. (3-15-22)

08. Emergency Action. If the Radiation Control Program Director finds the public health, safety or welfare requires emergency action, the Director will incorporate findings in support of such action in a written notice of emergency revocation issued to the licensee. Emergency revocation is effective upon receipt by the licensee. Thereafter, if requested by the licensee in writing, the Director will provide the licensee a revocation hearing and prior notice thereof. Such hearings are conducted in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-15-22)

054. – 099. (RESERVED)

100. GENERAL PROVISIONS.
Sections 100 through 199 of these rules will be used for exclusions, modifications, and additions to Part A of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules. (3-15-22)

101. SCOPE.
Modification to Part A, Section A.1. Except as otherwise specifically provided, these regulations apply to all persons who receive, possess, use, transfer, own, or acquire any source of radiation; provided that nothing in these regulations applies to any person to the extent such person is subject to regulation by the Nuclear Regulatory Commission. (3-15-22)

102. DEFINITIONS.
Additions to Part A, Section A.2. (3-15-22)

01. Act. "Act" means Section 56-1053, Idaho Code. (3-15-22)

02. **Agency**. "Agency" means the Idaho Department of Health and Welfare. (3-15-22)

103. VIOLATIONS.
Modification to Part A, Section A.8. Any person who willfully violates any provision of the Act is subject to penalties under Section 56-1053, Idaho Code. (3-15-22)

104. IMPOUNDING.
Modification to Part A, Section A.9. Sources of radiation are subject to impounding under Section 56-1052, Idaho Code. (3-15-22)

105. COMMUNICATIONS.
Modification to Part A, Section A.12. All communications and reports concerning these rules, and applications filed under these rules, must be addressed to the Agency at Radiation Control Section, Idaho Department of Health and Welfare, Bureau of Laboratories, 2220 Old Penitentiary Road, Boise, Idaho 83712-8299. (3-15-22)

106. – 199. (RESERVED)

200. LICENSURE OF RADIATION MACHINE FACILITIES, (SERVICES) – AND ASSOCIATED HEALTHCARE PROFESSIONALS.
Sections 200 through 299 of these rules will be used for exclusions, modifications, and additions to Part B of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules. (3-15-22)

201. LICENSURE OF RADIATION MACHINE FACILITIES.
Exclusion to Part B, Section B.6. Subsection B.6.b is excluded from incorporation. (3-15-22)

202. RECIPROCAL RECOGNITION OF OUT-OF-STATE RADIATION MACHINES.
Modifications and additions to Part B, Section B.16. (3-15-22)

01. **Modification to Part B, Section B.16.a.iv**. States in which this machine is registered or licensed. (3-15-22)

02. **Addition to Part B, Section B.16 – New Subsection d**. The owner or person having possession of any radiation producing machine registered or licensed by a federal entity or state other than Idaho, or both, planning to establish regular operations in Idaho, must complete registration of the machine with the Agency within thirty (30) days after taking residence and prior to operation of the machine. Thirty (30) days prior to the expiration date of any out-of-state license for any radiation producing machine, the owner must apply to the Agency for a machine license. (3-15-22)

203. – 399. (RESERVED)

400. RADIATION SAFETY REQUIREMENTS FOR INDUSTRIAL RADIOGRAPHIC OPERATIONS.
Sections 400 through 499 of these rules will be used for exclusions, modifications, and additions to Part E of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules. (3-15-22)

401. LICENSING AND REGISTRATION REQUIREMENTS FOR INDUSTRIAL RADIOGRAPHY OPERATIONS.
Exclusions to Part E, Section E.5. Subsections E.5.b.i and E.5.b.ii, are excluded from incorporation. (3-15-22)

402. LEAK TESTING AND REPLACEMENT OF SEALED SOURCES.
Part E, Section E.10 is excluded from incorporation. (3-15-22)

403. QUARTERLY INVENTORY.
Part E, Section E.11 is excluded from incorporation. (3-15-22)

~~404. LABELING, STORAGE, AND TRANSPORTATION.~~
~~Exclusions to Part E, Section E14. Subsections E.14.a, E.14.b, and E.14.d, are excluded from incorporation.~~ ~~(3-15-22)~~

~~405. CONDUCTING INDUSTRIAL RADIOGRAPHIC OPERATIONS.~~
~~Exclusion to Part E, Section E.15. Subsection E.15.d is excluded from incorporation.~~ ~~(3-15-22)~~

~~406. RECORDS OF LEAK TESTING OF SEALED SOURCES AND DEVICES CONTAINING DU.~~
~~Part E, Section E.27 is excluded from incorporation.~~ ~~(3-15-22)~~

~~407. RECORDS OF QUARTERLY INVENTORY.~~
~~Part E, Section E.28 is excluded from incorporation.~~ ~~(3-15-22)~~

~~408. UTILIZATION LOGS.~~
~~Part E, Section E.29 is excluded from incorporation.~~ ~~(3-15-22)~~

~~409. LOCATION OF DOCUMENTS AND RECORDS.~~
~~Exclusions to Part E, Section E37. Subsections E.37.b.iii, E.37.b.xi, and E.37.b.xii are excluded from incorporation.~~ ~~(3-15-22)~~

~~410. NOTIFICATIONS.~~
~~Exclusions to Part E, Section E38. Subsections E.38.a.i, and E.38.a.ii are excluded from incorporation.~~ ~~(3-15-22)~~

~~411. APPLICATION AND EXAMINATIONS.~~
~~Part E, Section E.39 is excluded from incorporation.~~ ~~(3-15-22)~~

~~412. CERTIFICATION IDENTIFICATION (ID) CARD.~~
~~Part E, Section E.40 is excluded from incorporation.~~ ~~(3-15-22)~~

~~413. RECIPROCITY.~~
~~Part E, Section E.41 is excluded from incorporation.~~ ~~(3-15-22)~~

~~414. SPECIFIC REQUIREMENTS FOR RADIOGRAPHIC PERSONNEL PERFORMING INDUSTRIAL RADIOGRAPHY.~~
~~Part E, Section E.42 is excluded from incorporation.~~ ~~(3-15-22)~~

~~415. – 599. (RESERVED)~~

~~600. NOTICES, INSTRUCTIONS AND REPORTS TO WORKERS; INSPECTIONS.~~
~~Sections 600 through 699 of these rules will be used for exclusions, modifications, and additions to Part J of the Suggested State Regulations for Control of Radiation, Volume 1, as incorporated in Section 004 of these rules.~~ ~~(3-15-22)~~

002. DEFINITIONS.

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

02. Qualified Expert. An individual who meets nationally recognized radiation safety standards and has specific training in shielding design and X-ray safety. ( )

03. Radiation Safety Program. A documented program that ensures compliance with radiation protection standards, including safety procedures, training and quality control. ( )

003. LICENSE REQUIREMENTS AND APPLICATION.

01. Federal Facilities. All X-ray machines except those owned and operated at federal facilities or exempted under Section 56-1046(4), Idaho Code, must be licensed with the Department. ( )

02. License Application. Facilities must complete a license application approved by the Department. ( )

03. Insurance and Financial Responsibility. Applicants must provide documentation of adequate insurance coverage and financial responsibility to ensure compliance with safety standards and regulatory obligations. ( )

004. LICENSE RENEWAL AND FEES.

01. License Renewal. X-ray licensees must comply with the renewal cycles and fees as determined in the following table:

X-Ray Renewal Cycle and Facility Fees

Facility Type	Renewal Cycle	Base Fee	Per Tube Fee
Hospital, Clinic, Medical Practice	2 Years	$50	$25
Dental, Chiropractic, Podiatric, Veterinary Practice	4 Years	$50	$25
Industrial, research, academic/ educational, or security	10 Years	$50	$25

( )

02. Licensing Fee Due Dates and Late Penalties. Fees are due within thirty (30) calendar days of the renewal date. A late fee of fifty ($50) will be assessed at thirty-one (31) days past the renewal date. If the fees are not paid by day ninety-one (91) past the renewal date, licensure will be terminated. ( )

03. Radiation Safety Program Flat Fee. A facility or group of facilities under one administrative control that has a full-time in-house radiation safety program that includes X-ray machines, may pay a flat annual facility fee of one thousand dollars ($1,000) instead of the base and per tube fees. Facilities must submit annual documentation of their quality assurance and quality control program for review by the Department. ( )

04. Recognition of Other Licenses. The Department will recognize out-of-state or federally licensed X-ray machines until the next required renewal cycle, when such licenses meet equivalent safety and operational standards to minimize duplicative licensing requirements. Facilities with federal or out-of-state licenses must register with the Department within thirty (30) days. ( )

005. X-RAY SHIELDING PLAN APPROVAL.

Facilities housing X-ray machines must have a qualified expert conduct a site-specific shielding plan. A copy of this plan, including the floor plan and site-specific shielding calculations, must be submitted to the Department within thirty (30) days before conducting imaging procedures on patients. ( )

006. ON-SITE INSPECTION.

Qualified representatives of the Department are authorized to inspect the premises and operations of all licensed X-ray facilities to determine the adequacy of their shielding, quality control, quality assurance, safety, training, and other X-ray control programs. Department representatives will issue a written inspection report of findings, list items requiring a response, and specify the response timeframes required to maintain licensure. ( )

007. X-RAY MACHINE QUALITY CONTROL AND QUALITY ASSURANCE.

01. Quality Control. Licensed facilities must follow all X-ray machine manufacturer's required quality control procedures. Quality control records must be available for review by the Department and retained for at least two (2) license renewal cycles. ( )

02. Quality Assurance. Licensed facilities must have a written quality assurance plan documenting how quality control records are reviewed, safety procedures are followed, and X-ray machine operators are appropriately trained. ( )

008. X-RAY MACHINE PERFORMANCE STANDARDS.

01. Radiation Output. X-ray machines must have a consistent radiation output within specified limits. ( )

02. Image Quality. The machines must produce high-quality images with sufficient contrast, resolution, and minimal noise. ( )

03. Safety Features. X-ray machines must include the following safety features: ( )

a. Beam Lighting Devices: to restrict the X-ray beam to the area of interest and reduce patient exposure; ( )

b. Warning Lights and Signals: to indicate when the machine is in operation; and ( )

c. Interlocks: to prevent accidental exposure by ensuring that the X-ray beam is only activated when the machine is properly configured. ( )

04. Maintenance and Calibration. Regular maintenance and calibration of X-ray machines are required to ensure they operate within specified performance standards. ( )

05. Compliance. X-ray machines used for human imaging must comply with (a) or (b) and must comply with (c): ( )

a. U.S. Food and Drug Administration (FDA): FDA regulations on radiation-emitting products. ( )

b. International Electrotechnical Commission (IEC): IEC standards for medical electrical equipment. ( )

c. Documentation of compliance should be maintained for two (2) license renewal periods and be made available for inspection by regulatory authorities. ( )

009. X-RAY FACILITY AND OPERATOR TRAINING REQUIREMENTS.

01. Facility Requirements. Licensed facilities must: ( )

a. Post notice standards for protection against radiation in the facility; ( )

b. Keep radiation exposure as low as is practical; ( )

c. Provide written, site-specific, emergency procedures; ( )

d. Provide written, site-specific, safety procedures as they apply to each machine; ( )

e. Provide written, site-specific, operating procedures as they apply to each machine; ( )

f. Provide and document staff training; and ( )

g. Ensure personnel wear monitoring devices, if applicable. ( )

02. Operator Training Requirements. No individual will be permitted to operate an X-ray machine

until they have completed training and proven competency in radiation safety topics. Licensed facilities must retain written training records for each X-ray machine operator. Training records for current and former X-ray operators must be made available upon request. Training records must be retained for a minimum of two (2) license renewal cycles. X-ray operator training must include the following topics: ( )

a. Fundamental of radiation safety; ( )

b. Characteristics of gamma and X-radiation; ( )

c. Units of radiation dose (millirem); ( )

d. Bioeffects of excessive exposure to radiation; ( )

e. Levels of radiation emitted from X-ray machines; ( )

f. Methods of controlling radiation dose including working time, distance, and shielding; ( )

g. State and federal radiation protection standards; ( )

h. Proper use of site-specific radiation survey instruments; ( )

i. Use of personnel monitoring equipment; ( )

j. Proper use of site-specific X-ray machines; and ( )

k. Site-specific operating and emergency procedures. ( )

010. LICENSE MODIFICATION, SUSPENSION, OR REVOCATION.
The Department may modify, suspend, or revoke an X-ray license if materially false statements are made by the licensee on the application, for failure to respond to inspection findings in a timely manner, or if the Department finds that the X-ray producing device is used in a fashion that endangers patients, facility staff, or the public. ( )

~~601~~011. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.21 – DEVELOPMENTAL DISABILITIES AGENCIES (DDA)

DOCKET NO. 16-0321-2501 (CHAPTER REWRITE)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-4605, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 9, 2025 **2:00 PM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m3b53e9aad0b5c7a8406b205b66d2e692** **Join by meeting number** **Meeting number (access code): 2820 182 3802** **Meeting password: TpZmsjq2e86** **Meeting password when dialing from a phone or video system: 87967572** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Friday, June 20, 2025 **2:00 PM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m909cd0ca85fdb797c81a68a9b3ffbee3** **Join by meeting number** **Meeting number (access code): 2830 045 5205** **Meeting password: YBpf4VRZe83** **Meeting password when dialing from a phone or video system: 92734879** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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

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

This chapter is a consolidation of IDAPA 16.03.21 (Developmental Disabilities Agencies) and IDAPA 16.04.17 (Residential Habilitation Agencies). Consolidating these two chapters will assist the Department and providers with efficiency and consistency while reducing regulatory burden and ensure the health and safety of the vulnerable individuals these organizations serve. This chapter includes requirements for Adult Residential Care Facilities that provides residential services to adult individuals with developmental disabilities.

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

Fees will not be increased as a result of this rulemaking.

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

There is not anticipated to be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted for the consolidated document of both 16.04.17 and 16.03.21. Stakeholders were provided with the draft document showing the proposal to repeal 16.04.17 and insert components into 16.03.21. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, Volume 25-4, pages 27 and 28.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25th, 2025.

DATED this 2nd day of May, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
DHWRules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0321-2501
(Chapter Rewrite)

16.03.21 – DEVELOPMENTAL DISABILITIES AGENCIES (DDA), RESIDENTIAL HABILITATION AGENCIES, AND ADULT RESIDENTIAL CARE FACILITES

000. LEGAL AUTHORITY.
Section 39-4605, Idaho Code, authorizes the Idaho Board of Health and Welfare to adopt rules and standards of

certification for Developmental Disabilities Agencies, Residential Habilitation Agencies, and Adult Residential Care Facilities, to promote the health and safety of participants. These entities will be referred to as an organization for this rule chapter. ~~(3-17-22)~~( )

001. SCOPE.
These rules govern developmental disabilities agencies, residential rehabilitation agencies, and adult residential care facilities.~~:~~ ~~(3-17-22)~~( )

~~**01. Certification**. The granting, denial, or revocation of certification is based on whether agencies are adequate for the health, safety, and the care, treatment, maintenance, training, and support of participants under these rules. (3-17-22)~~

~~**02. Application**. Any person, corporation, or association may apply to the Department for approval and certification of the applicant's DDA. (3-17-22)~~

002. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Verification of Compliance. The ~~agency~~ organization must verify that all employees, subcontractors, agents of the ~~agency~~ organization, and volunteers ~~delivering DDA services~~ have complied with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~( )

~~**02. Reporting Criminal Convictions, Pending Investigations, or Pending Charges**. Once an employee, subcontractor, agent of the agency, or volunteer delivering DDA services has received a criminal history clearance, any additional criminal convictions, pending investigations, or pending charges must be reported to the Department as listed in IDAPA 16.05.06, "Criminal History and Background Checks," Subsections 210.01 and 02 by the close of the next business day when the agency learns of the convictions, investigations, or changes. (3-17-22)~~

010. DEFINITIONS -- A THROUGH Z.
For the purposes of this chapter of rules, the following terms apply. (3-17-22)

~~**01. ADA**. The "Americans with Disabilities Act Accessibility Guidelines," under 28 CFR Part 36, Appendix A. (3-17-22)~~

~~**02. Center-Based Services**. Services provided in a location under control of the agency through ownership or lease agreement that meets requirements under Section 400 of these rules. (3-17-22)~~

01. Abuse. The non-accidental act of sexual, physical, verbal, or mental mistreatment, or injury of a participant through the action or inaction of another individual. ( )

02. Adult Residential Care Facility. A facility that provides any service or group of services which provide care to the developmentally disabled on an inpatient or residential basis. ( )

03. Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of developmentally disabled, mentally ill, or elderly participants. ( )

0~~3~~4. Communicable Disease. A disease that may be transmitted from one (1) person or animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death. (3-17-22)

0~~4~~5. Deficiency. A determination of non-compliance with a specific rule or part of rule. (3-17-22)

0~~5~~6. Department. The Idaho Department of Health and Welfare. (3-17-22)

~~**06. Developmental Disability**. A developmental disability, defined in Section 66-402, Idaho Code.~~

~~(3-17-22)~~

07. Developmental Disability Agency (DDA). A business entity~~, also known as "agency,"~~ that meets the definition of a developmental disabilities facility provided in Section 39-4604(3), Idaho Code, that is certified by the Department to provide services to eligible individuals ~~with developmental disabilities under these rules~~. ~~(3-17-22)~~( )

08. Exploitation. An action that may include, but is not limited to, the unjust or improper use of a vulnerable participant's financial power of attorney, funds, property, or resources by another person for profit or advantage. ( )

0~~8~~9. Health Care Professional. An individual licensed to provide health care within their respective discipline and scope of practice. (3-17-22)

~~**09. Implementation Plan**. A plan that details how goals from the plan of service will be accomplished.~~ ~~(3-17-22)~~

~~**10. Natural Setting**. The environment where an activity or behavior naturally occurs that is typical for peers of the participant's age, such as the home and community, where the participant lives or participates in activities, and in the service environment indicated.~~ ~~(3-17-22)~~

10. Immediate Jeopardy. A level of non-compliance with one (1) or more requirements in this chapter that has caused, or is likely to cause, serious injury, harm, impairment, or death to a participant that requires an immediate response. ( )

11. Maladaptive Behavior. Any behavior that significantly interferes with participant care or presents a danger to self or others. ( )

12. Medication. Any substance or drug used to treat a disease, condition, or symptoms that may be taken orally, injected, or used externally, and is available through prescription or over the counter. ( )

13. Neglect. The failure to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health of a vulnerable adult as defined in Section 18-1505, Idaho Code. ( )

1~~1~~4. Participant. An individual receiving services through a DDA, Residential Habilitation Agency or Adult Residential Care Facility. ~~(3-17-22)~~( )

15. Residential Habilitation. Services consisting of an integrated array of individually tailored services and supports furnished to an eligible participant that are designed to assist them to reside successfully in their own home. Services include personal care services, and skill training. Individuals who provide residential habilitation services must be employed by a residential habilitation agency. ( )

16. Physical Restraint. Any manual hold or mechanical device that the participant cannot remove easily, and which restricts the free movement of or normal functioning of any portions of a participant's body. ( )

1~~2~~7. Plan of Service. An initial plan, annual plan, or addendum that identifies all services~~, supports, or both, if applicable~~ offered. ~~(3-17-22)~~( )

1~~3~~8. Repeat Deficiency. ~~A violation or deficiency found on a resurvey or revisit to a DDA that was also found during the previous survey or visit~~ The Department has found an organization is out of compliance with a rule and received a citation on two (2) consecutive surveys. ~~(3-17-22)~~( )

19. Substantial Compliance. A level of compliance that has not or will not cause significant injury that requires medical attention to a participant. ( )

~~14~~20. Survey. A review conducted by the Department to determine compliance with statutes and rules.

(3-17-22)

21. **Time Out**. A separate unlocked room or location, that is supervised, that is used to remove a participant from stimulation that may be triggering or reinforcing maladaptive behavior. ( )

011. ~~--074.~~ ~~**(RESERVED)**~~

~~**SERVICES PROVIDED BY DEVELOPMENTAL DISABILITIES AGENCIES**~~
~~**Sections 075-099**~~

~~**075.** **DDA SERVICES.**~~
~~A DDA provides services that include evaluation, diagnostics, skill development, intervention, and support services that are provided in the community, home, or center to individuals eligible to receive services.~~ ~~(3-17-22)~~

~~**076. --**~~ **099.** **(RESERVED)**

~~**CERTIFICATION REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES AGENCIES**~~
~~**Sections 100-299**~~

100. ~~**TYPES OF CERTIFICATES ISSUED**~~**CERTIFICATION REQUIREMENTS FOR DDA, RESIDENTIAL HABILITATION AGENCIES, AND ADULT RESIDENTIAL CARE FACILITIES**.
~~The Department issues certificates in effect for a period no longer than three (3) years. The types of certificates issued are as follows:~~ ~~(3-17-22)~~

~~**01.** **Initial Certificate**. When the Department determines application requirements have been met, an initial certificate is issued for a period of up to six (6) months from the initiation of services. The Department will survey the agency prior to the certificate expiration date to ensure substantial compliance with these rules. When the agency is determined to be in substantial compliance, a one (1) year certificate will be granted.~~ ~~(3-17-22)~~

~~**02.** **One-Year Certificate**. A one (1) year certificate is issued by the Department when it determines the agency is in substantial compliance with these rules, following an initial or provisional certificate, or when there may be areas of deficient practice that would impact the agency's ability to provide adequate care. An agency is prohibited from receiving consecutive one (1) year certificates.~~ ~~(3-17-22)~~

~~**03.** **Three-Year Certificate**. A three (3) year certificate is issued by the Department when it determines the agency requesting certification is in substantial compliance with these rules.~~ ~~(3-17-22)~~

~~**04.** **Provisional Certificate**. When an agency is found to be out of substantial compliance with these rules but does not have deficiencies that jeopardize the health or safety of participants, a provisional certificate may be issued by the Department for up to a six (6) month period.~~ ~~(3-17-22)~~

~~**a.** A provisional certificate is issued contingent upon the correction of deficiencies under a plan developed by the agency and approved by the Department.~~ ~~(3-17-22)~~

~~**b.** Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules.~~ ~~(3-17-22)~~

~~**c.** If the Department determines the agency is in compliance, a one (1) year certificate will be issued. If the agency is determined to be out of compliance, the certificate will be revoked.~~ ~~(3-17-22)~~

~~**101.** **APPLICATION FOR INITIAL CERTIFICATION.**~~

~~**01.** **Certification Required**. Before any agency can operate and provide services as a DDA, it must apply for, obtain, and maintain DDA certification from the Department.~~ ~~(3-17-22)~~

~~**02.** **Department Review Not Guaranteed**. The Department may choose not to consider the~~

~~application of any operator, administrator, or owner of an agency whose license or certification has been revoked until five (5) years have lapsed from the date of revocation.~~ ~~(3-17-22)~~

~~**03. Open Application**. An applicant may apply up to three (3) times within a three hundred sixty-five (365) day period starting on the date of the first submission. If the application is incomplete upon a third submission, the application will be denied. The applicant may not resubmit an application for six (6) months from the date of the denial notice.~~ ~~(3-17-22)~~

01. Application for Initial Certification. Certification will be issued to any organization upon completing an application demonstrating compliance with these rules ( )

042. Content of Application for Certification. The ~~A~~application ~~for certification must be submitted to the Department on the Department-approved form with the following information and supporting documents at least sixty (60) days prior to the planned opening~~ must include: ~~(3-17-22)~~( )

~~**a.** An application form that contains name, address, and telephone number of the agency, type of services to be provided, the geographic service area of the agencies, and the anticipated date for the initiation of services;~~ ~~(3-17-22)~~

~~**b**~~**a.** ~~An accurate and complete statement of all b~~Business names of the ~~agency~~ organization as filed with the Secretary of State~~, whether it is an assumed business name, partnership, corporation, limited liability company, or other entity that identifies each owner and the management structure of the agency~~; ~~(3-17-22)~~( )

~~**c.** A statement that the agency will comply with these rules and all other applicable local, state, and federal requirements, including an assurance that the agency complies with pertinent state and federal requirements governing equal opportunity and nondiscrimination;~~ ~~(3-17-22)~~

~~**d**~~**b.** ~~A copy of the proposed o~~Organizational chart or plan for staffing ~~of the agency~~; ~~(3-17-22)~~( )

c. The following Policies and Procedures; ( )

~~**e**~~i. ~~Written policies and procedures addressing qualifications to meet service delivery requirements including resumes, job descriptions, verification of criminal history clearance, and copies of state licenses and certificates, when applicable~~Staff and volunteer qualifications including, roles, responsibilities and organization expectations; ~~(3-17-22)~~( )

~~**f**~~ii. ~~Written policies and procedures for the development and implementation of personnel training to meet the requirements of Section 302 of these rules~~Staff training that is specific and appropriate to the population served; ~~(3-17-22)~~( )

~~**g**~~iii. ~~Personnel and participant illness policy, communicable disease policy, and other health related policies and procedures~~Infection prevention measures to mitigate the spread of communicable diseases; ~~(3-17-22)~~( )

iv. General health care services including assessment and treatment of acute and chronic complaints or situations. ( )

~~**h**~~v. ~~Written t~~Transportation safety ~~policies and procedures required in Section 402 of these rules~~, including the organization's preventive maintenance program, inspection intervals, insurance coverage, and licensed driver requirements for organization owned vehicles, and a policy for staff owned vehicles, if applicable; ~~(3-17-22)~~( )

vi. ~~Written participant grievance policies and procedures to meet requirements in Section 406 of these rules~~The organization must ensure the participant and the guardian, if applicable, has been informed of how to file a grievance. The organization must respond to the grievance within fourteen (14) days or less; ~~(3-17-22)~~( )

~~**i**~~vii. ~~Written medication policies and procedures to address medication standards to meet requirements~~

~~in Section 405 of these rules~~Medication standards; ~~(3-17-22)~~( )

~~k~~viii. ~~Written policies and procedures that address the development of positive behavior supports to meet requirements in Section 510 of these rules~~Behavior Management, including approved interventions to manage inappropriate or maladaptive behaviors, and restraints if applicable; ~~(3-17-22)~~( )

~~l~~ix. ~~Written policies and procedures for reporting incidents to the adult protection, child protection authority, or both, and to the Department to meet requirements in Section 404 of these rules~~Reporting incidents of abuse, neglect and exploitation including notifying the proper authorities; ~~(3-17-22)~~( )

x. Incident Reports for all events that occur during service delivery that interfere with the participants' safety or ability to participate; ( )

~~m. A written code of ethics policy reflecting nationally recognized professional standards of practice. The policy must articulate basic values, ethical principles and standards for confidentiality, conflict of interest, exploitation, and inappropriate boundaries in an agency's relationship with participants, relatives, or with other agencies; (3-17-22)~~

~~n. Complete administrator and supervisor records as required in Subsection 301.04 of these rules; (3-17-22)~~

~~o. Sample of the following documents: (3-17-22)~~

~~i. Complete participant record as required in Subsection 301.05 of these rules; (3-17-22)~~

~~ii. Program billing; (3-17-22)~~

~~iii. Quality assurance program developed to meet requirements in Section 500 of these rules; (3-17-22)~~

~~iv. All documents referenced in the application. (3-17-22)~~

~~p. Any other information requested by the Department for determining the agency's compliance of these rules or the agency's ability to provide the services for which certification is requested; (3-17-22)~~

xi. Termination of services that ensures the safety of the participant and notifies all relevant parties; ( )

xii. The organization will only accept and retain participants for whom the organization has the appropriate staff and skills to provide the services; and ( )

xiii. Each organization must ensure the rights provided under Section 66-412, Idaho Code, and will ensure the participant's privacy and confidentially, promote independence in the community and allow participants to refuse services. ( )

~~q~~d. ~~When center-based services are to be provided, the agency must include the following and meet requirements under Section 400 of these rules~~DDA center and Adult Residential Care Facilities must include the following: ~~(3-17-22)~~( )

~~i. Address and telephone number for each service location; (3-17-22)~~

i~~i~~. ~~Supporting documentation requirements including the ADA checklist, local fire safety inspection, and local building and zoning compliance~~"Americans with Disabilities Act Accessibility Guidelines," under 28 CFR Part 36, Appendix checklist, local fire safety inspection, and Certificate of Occupancy; and; ~~(3-17-22)~~( )

ii~~i~~. ~~Written p~~Policies and procedures ~~covering the protection of all individuals in the event of fire and other emergencies to include emergency evacuation procedures; and~~for responding to fire, emergencies, including emergency evacuation plans. ~~(3-17-22)~~( )

~~iv. A site review completed by the Department prior to the initiation of center based services verifying compliance with these rules.~~ ~~(3-17-22)~~

03. Denial of an Application. The Department may deny any application for the following reasons; ( )

a. The applicant is not in substantial compliance with these rules; ( )

b. The applicant has willfully misrepresented or omitted information on the application; or ( )

c. The administrator or owner of an organization whose certification has been revoked within the last five (5) years. ( )

04. Certificate. The Department will issue an initial six (6) month certificate when it is determined the organization is in substantial compliance. Following the initial or a provisional certificate the Department will issue a one year (1-year) certificate, or as needed to determine compliance with rules. A three (3) year certificate is issued when it is determined the organization is in substantial compliance. ( )

a. Application of renewal. An organization must apply to renew its certificate no less than sixty (60) days before the expiration date. ( )

b. Expiration. Expiration of a certificate without a timely request for renewal rescinds the organization's certificate. ( )

c. DDA Center and Adult Residential Care Facility, the certificate must be posted and visible to the public. ( )

05. Survey and Investigations. ( )

a. Investigation Survey. The Department will investigate complaints of alleged rule violations. Complainant information is kept confidential. ( )

b. Method of Investigation. The Department will determine the method used to investigate the complaint. ( )

c. Notification to Complainant. The Department will provide a written response to the complainant upon completion of the investigation. ( )

d. Licensing and Certification will conduct survey and investigation at specified intervals to determine compliance with this chapter of rules and Title 66, Chapter 4, Idaho Code and Section 39-4605, Idaho Code. ( )

06. Notification To the Department. ( )

a. The Department must be notified when the organization's owner, administrator, service area, or address changes; and ( )

b. New ownership, certificates are not transferable. ( )

10~~2~~1. -- 1~~09~~16. (RESERVED)

~~110. DEPARTMENT'S WRITTEN DECISION REGARDING APPLICATION FOR CERTIFICATION.~~
~~The Department will provide to the agency, within thirty (30) days of the date the completed application packet is received, a written decision regarding certification. An application is considered completed when all required documents are received and comply with these rules.~~ ~~(3-17-22)~~

111. DENIAL OF AN APPLICATION.
The Department may deny any application. (3-17-22)

01. Causes for Denial. Causes for denial of an application may include: (3-17-22)

a. The application does not meet rule requirements in Subsection 101.04 of these rules; (3-17-22)

b. The applicant, owner, operator, or provider has: (3-17-22)

i. Willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; (3-17-22)

ii. Been denied or has had revoked any license or certificate for a DDA, facility, certified family home, or residential habilitation agency; or (3-17-22)

iii. Been convicted of operating an unlicensed or uncertified DDA, facility, certified family home, or residential habilitation agency; (3-17-22)

iv. A court order that mandates the applicant must not operate a DDA, facility, certified family home, or residential habilitation agency; (3-17-22)

v. An action, either current or in process, against a certificate held by the applicant either in Idaho or any other state or jurisdiction. (3-17-22)

02. Before Denial is Final. The Department will advise the individual or provider in writing of the denial and their right and method to appeal. Contested case hearings, including denial and revocation, must be conducted under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)

112. – 114. (RESERVED)

115. CHANGES THAT REQUIRE REPORTING.

01. Notification To The Department. (3-17-22)

a. When a change of a certified agency's ownership, administrator, geographic service area, or address is contemplated, the owner or designee must notify the Division of Licensing and Certification in writing through the Department-approved process. (3-17-22)

02. Center-Based Services. When an agency plans to provide center-based services in a new physical location, on a temporary or permanent basis, the Department will conduct a site review within thirty (30) days after the agency has relocated. Included with the notification required under this rule, the agency must provide: (3-17-22)

a. Evidence of review and approval by the local fire and building authorities, including issuance of occupancy permit; (3-17-22)

b. A checklist that verifies compliance with the ADA requirements and Subsection 400.01 of these rules.; and (3-17-22)

c. Written policies and procedures covering the protection of all individuals in the event of fire and other emergencies to include emergency evacuation procedures. (3-17-22)

03. Updated Certificate Necessary. To continue operation after any such anticipated change, the DDA must receive an updated certificate from the Department that reflects the change(s). An agency that fails to notify the Department of such changes is operating without a certificate. (3-17-22)

04. New Ownership. For new ownership, the new owner must submit a new application to the Division of Licensing and Certification through the approved process at least sixty (60) days prior to the proposed

~~date of change under Section 101 of these rules.~~ ~~(3-17-22)~~

~~**116. CERTIFICATE NOT TRANSFERABLE.**~~
~~The certificate is issued only to the agency named in the application, for the period specified, and for the location indicated in the application, and to the owners or operators as expressed on the application submitted to the Department. The certificate may not be transferred or assigned to any other person or entity. The certificate is nontransferable from one (1) location to another.~~ ~~(3-17-22)~~

~~**117. RESTRICTION ON CERTIFICATION.**~~
~~A business entity established by a parent for the sole purpose of providing DDA services to their own child cannot be certified as a DDA.~~ ~~(3-17-22)~~

~~**118. AVAILABILITY OF CERTIFICATE.**~~
~~The certificate must be posted in a conspicuous location in the DDA where it may be seen readily by the participants and members of the public.~~ ~~(3-17-22)~~

11~~9~~7. ~~AGENCIES~~ ORGANIZATIONS APPROVED THROUGH NATIONAL ACCREDITATION.
~~Agencies approved by national accrediting bodies must maintain Department certification requirements in the following~~Organizations that are accredited are required to produce the following records to renew a certificate:
~~(3-17-22)~~( )

01. The Current Accreditation Verification or Report. (3-17-22)

02. Criminal History Background Check Requirements. ~~See Section 009 of these rules;~~
~~(3-17-22)~~( )

03. ~~Personnel~~ Staff Records. ~~See Subsection 301.04 of these rules;~~ ~~(3-17-22)~~( )

~~**04. General Training Requirements**. See Section 302 of these rules; and~~ ~~(3-17-22)~~

~~**05. Facility Standards for Agencies Providing Center Based Services**. See Section 400 of these rules.~~ ~~(3-17-22)~~

~~**120. RENEWAL AND EXPIRATION OF THE CERTIFICATE.**~~

~~**01. Renewal Request**. An agency must request renewal of its certificate no less than ninety (90) days before the expiration date of the certificate, to ensure there is no lapse in certification.~~ ~~(3-17-22)~~

~~**02. Expiration Without Timely Request for Renewal**. Expiration of a certificate without a timely request for renewal automatically rescinds the agency's certificate to deliver services under these rules. If an agency's certificate is rescinded, a new application for certification must be submitted to deliver services under these rules.~~
~~(3-17-22)~~

1~~21~~18. -- 299. (RESERVED)

GENERAL ~~AGENCY~~ ORGANIZATION QUALIFICATIONS AND REQUIREMENTS
Sections 300-399

300. GENERAL STAFFING REQUIREMENTS ~~FOR AGENCIES~~.
~~Each DDA is accountable for all operations, policy, procedures, and service elements of the agency~~The organization must have a qualified administrator, supervisor and direct service provider (DSP) to meet the needs of participants served. The organization administrator and supervisor can be the same individual if the organization can meet requirements of each duty.
~~(3-17-22)~~( )

01. ~~Agency~~ Administrator Qualifications and Duties. The ~~agency~~ administrator must have two (2) years of supervisory experience with the population served ~~in an administrative role~~. On a temporary basis, ~~A~~an administrator may ~~designate a qualified individual to perform~~ delegate administrative functions on their behalf. The

administrator or their designee is responsible for the overall operations of the organization, including compliance with these rules. ~~(3-17-22)~~( )

~~**02. Agency Administrator Duties**. An agency administrator is accountable for the overall operations of the agency, including ensuring compliance with these rules, overseeing and managing personnel, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (3-17-22)~~

~~**03. Supervisor Qualifications**. The agency must have documentation that ensures personnel acting in a supervisory capacity meets qualifications as required by the payer source for the service provided. The agency administrator and supervisor can be the same individual if the agency can meet requirements of each duty. (3-17-22)~~

042. Supervisor Duties. Complete or obtain the plan of service, supervise DSP, including at least quarterly supervision, and coordinate other service providers to ensure continuity of service delivery. ~~(3-17-22)~~( )

~~**a.** Complete or obtain participant assessments and plans according to the authorized plan of service. (3-17-22)~~

~~**b.** Provide personnel initial direction, procedural guidance, and monthly supervision of work performed to ensure programs are implemented as written and demonstrate the necessary skills to provide the services. (3-17-22)~~

~~**05. Direct Service Provider (DSP) Qualifications**. A person qualified to provide services must meet the qualifications prescribed for the type of services to be rendered and training requirements of Section 302 of these rules. (3-17-22)~~

063. DSP Duties. Perform tasks as assigned under the direction of a supervisor. Tasks may not be assigned that require specific certification or licensure. (3-17-22)

074. Parent or Legal Guardian of Participant. A DDA may not hire the parent or legal guardian of a participant to provide services to the parent's or legal guardian's child. (3-17-22)

~~**08. Volunteer Workers in a DDA**. If volunteers are utilized, the agency must establish written policies and procedures governing the screening, training, and utilization of volunteer workers. If a volunteer is working directly with participants, they must meet the qualifications, training, and record requirements of a DSP. (3-17-22)~~

301. ~~AGENCY~~ ORGANIZATION RECORD REQUIREMENTS.

01. Accessibility of ~~Agency~~ Records. ~~The agency~~ An organization's records ~~required under these rules~~ must be ~~accessible~~ available to the Department ~~during normal operations of the agency for the purpose of inspection and copying, with or without prior notification, under Section 39-4605(4), Idaho Code~~, with or without prior notification. ~~(3-17-22)~~( )

02. General Record Requirements. ~~Each agency certified under these rules~~ The organization must maintain accurate, current, and complete ~~administrative, personnel, and participant~~ records for ~~at least~~ a minimum of five (5) years. ~~(3-17-22)~~( )

~~**03. Administrative Records**. Records must include: (3-17-22)~~

~~**a.** An organizational chart; (3-17-22)~~

~~**b.** Legal authority identified in organizational bylaws or other documentation of legal authority of ownership; and (3-17-22)~~

~~**c.** Fiscal records verifying service delivery prior to request for payment. (3-17-22)~~

043. ~~Personnel~~ Staff Records. Records must ~~include~~ contain the following: ~~(3-17-22)~~( )

a. Name, ~~current~~ address, ~~and~~ phone number ~~of the employee~~, date of hire and termination, if applicable; ~~(3-17-22)~~( )

b. Documentation supporting qualifications to carry out assigned duties; (3-17-22)

~~**c.** Verification of satisfactory completion of criminal history checks under IDAPA 16.05.06, "Criminal History and Background Checks." (3-17-22)~~

~~**d.** Date of Employment; (3-17-22)~~

~~**e.** Documentation of training under Section 302 of these rules; (3-17-22)~~

~~**f.** Evidence of current age-appropriate CPR and first aid certifications; (3-17-22)~~

~~**g.** Current assistance with medications certification, if applicable; (3-17-22)~~

~~**h.** Other current certifications, as applicable; (3-17-22)~~

~~**i**~~**c.** ~~Obtain and maintain documentation of licenses and certifications for drivers and vehicles under public transportation laws, regulations, and ordinances that apply to the agency to conduct business and to operate the types of vehicles used to transport participants~~Current driver's license and automobile liability insurance for staff who transport participants; ~~(3-17-22)~~( )

~~**j.** Continuously maintain liability insurance that covers all passengers and meets the minimum liability insurance requirements under Idaho law. The agency will ensure that liability insurance coverage is carried to cover circumstances when an employee transports participants in their personal vehicle; and (3-17-22)~~

~~**k.** Date and reason for termination, if applicable. (3-17-22)~~

0~~5~~4. Participant Records ~~Requirements~~. ~~Each agency must have an organized participant records system to provide past and current information and to safeguard participant confidentiality under these rules that~~Records must contain the following: ~~(3-17-22)~~( )

a. ~~Clear documentation of the date, time, duration, and type of service with credentialed signature and corresponding initials of the individual providing the service, for each service provided.~~Documentation of type and duration of services delivered, including the date, time, and name of person providing the service; ~~(3-17-22)~~( )

~~**b.** Profile sheet containing the following information: (3-17-22)~~

~~**i**~~**b.** ~~Current living arrangement~~Name, address, phone number, and contact information of guardian (if applicable) or emergency contact; ~~(3-17-22)~~( )

~~ii. Complete address and contact information for the participant, guardian (if applicable), emergency contacts, and physician; (3-17-22)~~

~~iii. Current medications and allergies; and (3-17-22)~~

~~iv~~**c.** ~~Special~~General health information including specific dietary or medical needs~~.~~, and health care providers; ~~(3-17-22)~~( )

~~**e**~~**d.** Signed ~~N~~notification of participant rights, ~~access to~~ grievance procedures, and ~~the names, addresses, and telephone numbers of~~ contact information for protection and advocacy services that is clear and understandable; and; ~~(3-17-22)~~( )

~~**d**~~**e.** ~~Authorized p~~Plan of service ~~for the participant;~~ and incident reports. ~~(3-17-22)~~( )

~~c. Assessments from a health care professional, if relevant or needed for service provision due to medical or behavioral condition;~~ ~~(3-17-22)~~

~~f. An evaluation to be completed by a qualified supervisor or obtained by the agency, if applicable;~~ ~~(3-17-22)~~

~~g. Implementation plans, as applicable;~~ ~~(3-17-22)~~

~~h. Written documentation that identifies the participant's progress toward goals defined on their plan of service; and~~ ~~(3-17-22)~~

~~i. Incident reports under Section 404 of these rules.~~ ~~(3-17-22)~~

302. ~~GENERAL~~ TRAINING REQUIREMENTS.
~~Each DDA must ensure that all training of staff is completed as follows~~The organization must document all staff training, including the date, description of training, and name of the person conducting the training. Staff must be trained on the following: ~~(3-17-22)~~( )

01. Initial and Annual Training. Prior to working with participants and annually thereafter, ~~direct service providers are to~~ staff must complete: ~~(3-17-22)~~( )

a. Safety training ~~to include location based structural and environmental risks, and~~ on natural disasters; ~~(3-17-22)~~( )

b. Abuse, neglect, and exploitation training covering definitions and reporting requirements; (3-17-22)

c. ~~Agency adopted ethical standards~~Organization's policy and procedures; ~~(3-17-22)~~( )

d. Participant's rights, advocacy resources, and confidentiality; and (3-17-22)

e. Behavior intervention strategies and techniques including appropriate responses to maladaptive behaviors; ( )

~~e~~f. ~~For center based services, fire training to include policies and procedures, fire drills, and emergency evacuation plans~~For DDA centers and Adult Residential Care Facility services, fire safety training, fire drills, and emergency evacuation plans. ~~(3-17-22)~~( )

02. CPR and First Aid Training. Staff must be certified in CPR and first aid prior to working alone with participants and ongoing thereafter. ( )

0~~2~~3. Participant ~~Sufficient~~ Specific Training. Prior to delivering services, DSPs must be trained on the specific needs of the participant including medical, or health requirements, and the use of assistive devices if applicable; ~~(3-17-22)~~( )

~~a. Prior to working alone with participants, DSPs will receive basic introductory review of participant information to provide services and supports, to include the following:~~ ~~(3-17-22)~~

~~i. Participant's profile sheet;~~ ~~(3-17-22)~~

~~ii. Correct and appropriate use of assistive technology used by participants; and~~ ~~(3-17-22)~~

~~iii. Special, medical, or health requirements.~~ ~~(3-17-22)~~

~~b. Supervisor will provide or ensure training provided by a designee on the following, as applicable:~~ ~~(3-17-22)~~

~~i. Instructional techniques including correct and consistent implementation of the participant's implementation plan or plan of service;~~ (3-17-22)

~~ii. Managing behaviors including techniques and strategies for teaching adaptive behaviors; and~~ (3-17-22)

~~iii. Accurate record keeping and data collection procedures;~~ (3-17-22)

~~**03. Certification Training**.~~ (3-17-22)

~~**a.** Prior to working alone with participants, personnel receive age appropriate certification in CPR and first aid, and maintain current certification thereafter; and~~ (3-17-22)

~~**b.** Personnel assisting with participant medications successfully complete the assistance with medications training course available through an Idaho college or university;~~ (3-17-22)

~~**c.** Personnel that implement physical restraints receive and maintain certification in a nationally recognized physical intervention strategy.~~ (3-17-22)

04. Ongoing Training. ~~The supervisor provides and ensures ongoing training of~~ DSPs must be trained when there are changes that impact services or supports including: ~~(3-17-22)~~( )

a. Participant's plan of service and corresponding implementation plans, as applicable; and (3-17-22)

b. Participant's physical, medical, and behavioral status. (3-17-22)

303. -- ~~399~~403. (RESERVED)

~~FACILITY, SAFETY, AND HEALTH STANDARDS~~
~~Sections 400-499~~

~~**400. FACILITY STANDARDS FOR AGENCIES PROVIDING CENTER-BASED SERVICES.**~~
~~When an agency is providing center-based services they must meet the following:~~ (3-17-22)

~~**01. Accessibility**. Agencies designated under these rules must be responsive to the needs of individuals receiving services and accessible to individuals with disabilities as defined in Section 504 of the federal Rehabilitation Act, the ADA, and the uniform federal accessibility standard. The DDA must submit a completed checklist to the Department with the application for certification to verify compliance with the ADA requirements.~~ (3-17-22)

~~**02. Environment**. The facilities of the agency must be designed and equipped to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control.~~ (3-17-22)

~~**03. Fire and Safety Standards**. Center based locations must:~~ (3-17-22)

~~**a.** Meet all local and state codes concerning fire and life safety that are applicable to a DDA through annual inspection by the local fire authority or Idaho State Fire Marshal's office as required by local, city, or county ordinances, documented with inspection results and corrective actions taken on violations cited;~~ (3-17-22)

~~**b.** Provide suitable fences, guards, or railings to protect participants on the premises where natural or man-made hazards are present;~~ (3-17-22)

~~**c.** Remove the accumulation of weeds, trash, and rubbish;~~ (3-17-22)

~~**d.** Limit and use of portable heating devices that have heating elements to not more than two hundred twelve degrees Fahrenheit (212°F), certified by Underwriters Laboratories, and approved by the local fire or building authority;~~ (3-17-22)

e. Properly label and store all hazardous or toxic substances under lock and key; (3-17-22)

f. Maintain water temperatures in areas accessed by participants at one hundred twenty degrees Fahrenheit (120°F) or below; and (3-17-22)

g. Have a telephone available on the premises with emergency numbers near the telephone for use in the event of an emergency. (3-17-22)

04. Evacuation Plans. Evacuation plans must be posted throughout the center and indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of the building. (3-17-22)

05. Fire Drills. The DDA must conduct and document quarterly fire drills. and meet the following: (3-17-22)

a. At least two (2) times each year these fire drills will include complete evacuation of the building; and (3-17-22)

b. A brief summary of each fire drill conducted, written, and maintained on file indicating the date, time, and duration the drill occurred, participants and personnel participating, problems encountered, and corrective action(s) taken. (3-17-22)

06. Food Safety and Storage. (3-17-22)

a. When the agency provides food service for participants and meets the definition of a "food establishment," in Section 39-1602, Idaho Code, the agency must comply with IDAPA 16.02.19, "Idaho Food Code." Compliance is verified through inspection by the local District Health Department. (3-17-22)

b. Refrigerators and freezers used to store participant foods will be maintained at or below forty-one degrees Fahrenheit (41°F), and ten degrees Fahrenheit (10°F) respectively, and in good repair. (3-17-22)

c. When medicines requiring refrigeration are stored in a food refrigerator, medicines must be stored in a package and kept inside a covered, leak-proof container that is clearly identified as a container for the storage of medicines. (3-17-22)

07. Housekeeping and Maintenance Services. The agency must meet the following: (3-17-22)

a. Maintain the interior and exterior of the center be maintained in a clean, safe, and orderly manner and kept in good repair; (3-17-22)

b. Not use deodorizers to cover odors caused by poor housekeeping or unsanitary conditions; (3-17-22)

c. Ensure the agency is free from infestations of insects, rodents, and other pests; and (3-17-22)

d. Maintain the temperature and humidity of the agency within a normal comfort range by heating, air conditioning, or other means. (3-17-22)

401. SETTING REQUIREMENTS.
The service setting must meet the needs of the participant as follows: (3-17-22)

01. Accessibility. Be accessible, safe, and appropriate. (3-17-22)

02. Environment. Be assessed to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control. (3-17-22)

~~03. Promote Inclusion. Promote the participant's inclusion in the natural setting. (3-17-22)~~

~~402. TRANSPORTATION POLICY.~~
~~Each agency must develop and implement transportation policies that include the following: (3-17-22)~~

~~01. Preventative Maintenance Program. Establish a preventive maintenance program for each agency-owned or leased vehicle, including vehicle inspections and other regular maintenance to ensure participant safety. (3-17-22)~~

~~02. Adequate Staffing. Ensure adequate staffing for participants who require additional supervision during transportation for the safety of all vehicle occupants. (3-17-22)~~

~~03. Licenses, Certifications, and Insurance for Drivers and Vehicles. Ensure adequate insurance coverage to protect the individuals utilizing agency transportation. This may include commercial vehicle insurance and employee vehicle insurance coverage. Obtain and maintain licenses, certifications, and insurance for drivers and vehicles required by public transportation laws, regulations, and ordinances. (3-17-22)~~

~~04. Laws, Rules, and Regulations. Adhere to all laws, rules, and regulations applicable to drivers and types of vehicles used. (3-17-22)~~

~~403. HEALTH POLICY.~~
~~Each DDA must develop and implement policies and procedures that: (3-17-22)~~

~~01. Ensure Personnel are Disease Free. Describe how the agency will ensure that personnel are free from communicable disease; (3-17-22)~~

~~02. Protect Participants. Describe how the agency will protect participants from exposure to individuals exhibiting symptoms of illness. (3-17-22)~~

~~03. Medication Standards. Implement medication requirements under Section 405 of these rules. (3-17-22)~~

~~04. Address Needs of Participants. Address any special medical or health care needs of participants as relevant to service delivery. (3-17-22)~~

404. ~~AGENCY~~ ORGANIZATION REPORTING ~~POLICY~~.
~~Each agency must develop and implement written policies and procedures outlining how the agency will document reporting and other communications for the following requirements: (3-17-22)~~

~~01. Incident Reports. Document all participant incidents that occur during service delivery and affect the ability to participate in services. Each report will document that the participant's legal guardian has been notified within twenty-four (24) hours. A documented review by the agency of all incident reports will be completed at least annually with written recommendations and retained by the agency for five (5) years. (3-17-22)~~

0~~2~~1. Reporting Requirements. ~~Any agency employee, contractor, or volunteer will report all suspected incidents and allegations of mistreatment, abuse, neglect, or exploitation to the administrator, adult or child protection authorities, or law enforcement under~~The organization will follow Sections 39-5303 and 16-1605, Idaho Code when there are allegations of abuse, neglect, or exploitation. The ~~agency~~ organization will protect the participant from the possibility of abuse during services while the investigation is in progress. The ~~administrator will ensure the events and the agency response to the events are documented in the participant record~~ organization will document their investigation of all alleged violations. ~~(3-17-22)~~( )

0~~3~~2. Reporting Incidents to the Department. ~~Through a Department approved process, the agency administrator or designee~~ The organization must notify the Division of Licensing and Certification by the close of the next business day of ~~any significant~~ the following incidents that occur to the participant during service hours ~~including~~: ~~(3-17-22)~~( )

a. Death; (3-17-22)

b. Hospitalization; (3-17-22)

c. Participant's arrest or incarceration; or (3-17-22)

d. When staff actions result in a report to protective or legal authorities. (3-17-22)

405. MEDICATION ~~POLICY~~.

Each ~~agency~~ organization must ~~develop and implement written medication policies and procedures that outline in detail how the agency will~~ ensure appropriate handling and safeguarding of medications. ~~If the agency chooses to assist participants with medications, the agency must also develop and implement specific policies and procedures to ensure assistance is safe and delivered by qualified, fully trained personnel~~ Staff assisting participants with medications must complete the assistance with medications training course available through a Department-approved training. ~~(3-17-22)~~( )

01. Handling of Participant's Medication. The ~~agency~~ organization must: ~~(3-17-22)~~( )

a. Maintain ~~that~~ the medication ~~is~~ in the original pharmacy-dispensed container, ~~original~~ over-the-counter container, or placed in a unit container (by a licensed nurse or pharmacy staff) appropriately labeled with the name of the medication, dosage, time to be taken, route of administration, and any special instructions. ~~Each medication will be packaged separately, unless in a Mediset, blister pack, or similar system.~~; ~~(3-17-22)~~( )

b. ~~Maintain evidence of the written or verbal order for the medication from the health care professional in the participant's record. Medisets~~Medication and treatment must be provided per the health care professional's orders. DDA's and residential habilitation agencies may use Medi sets filled and labeled by ~~a pharmacist~~ pharmacy staff or licensed nurse can serve as written evidence of the order. ~~An original prescription bottle labeled by a pharmacist describing the order and instructions for use can also serve as written evidence of an order from the health care professional.~~; and ~~(3-17-22)~~( )

~~**c.** Be responsible to safeguard the participant's medications while the participant is at the agency or in the community.~~ ~~(3-17-22)~~

c. The organization must store medications under the proper conditions and according to manufacturer's recommendations. ( )

d. ~~Not retain medications that are no longer used by the participant for longer than~~Discontinued or outdated medications must be removed from the participant's medication supply within thirty (30) calendar days. ~~(3-17-22)~~( )

02. Self-Administration of Medication. ~~Written approval is required when the participant is responsible for administering their own medication without assistance, stating the participant's health care professional has evaluated the participant's ability to self-administer medication, and has found that the participant:~~ A participant can self-administer medication when there is written approval from a health care professional supporting the participant is capable of completing this task safely. ~~(3-17-22)~~( )

~~**a.** Understands the purpose of the medication;~~ ~~(3-17-22)~~

~~**b.** Knows the appropriate dosage and times to take the medication;~~ ~~(3-17-22)~~

~~**c.** Understands expected effects, adverse reactions or side effects, and action to take in an emergency; and~~ ~~(3-17-22)~~

~~**d.** Is capable of taking the medication without assistance.~~ ~~(3-17-22)~~

03. Assistance with Medication. ~~An agency may assist participants with medications; however, only a health care professional may administer medications. Prior to unlicensed agency personnel assisting participants with~~

~~medication.~~ Staff must follow policy and procedures for assisting participants with medications, and the following conditions must be in place: ~~(3-17-22)~~( )

~~a. Personnel assisting with participant medications successfully complete the assistance with medications training course available through an Idaho college or university; (3-17-22)~~

~~b~~a. The participant's health condition is stable; and ~~(3-17-22)~~( )

~~c~~b. The participant's health status does not require nursing assessment before receiving the medication or nursing assessment of the therapeutic or side effects after the medication is taken; (3-17-22)

04. Medication Record. Record must contain the following: ( )

~~d. The medication is in the original pharmacy-dispensed container with proper label and directions, in an original over-the-counter container, or the medication has been placed in a unit container by a licensed nurse. Proper measuring devices will be available for liquid medication that is poured from a pharmacy-dispensed container; (3-17-22)~~

~~e. Written and oral instructions from a physician, practitioner of the healing arts, health care professional, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions, side effects, and action to take in an emergency have been reviewed. (3-17-22)~~

~~f. Written instructions are in place that outline required documentation of assistance including the following: (3-17-22)~~

~~i~~a. Name of the participant; (3-17-22)

~~ii~~b. Name and dosage of the medication given; (3-17-22)

~~iii~~c. Time and date the medication was given; (3-17-22)

~~iv~~d. Initials of individual assisting with medication that can be verified with matching signature; (3-17-22)

~~v~~e. Documentation of medication errors ~~to~~, include~~e~~ing ~~any~~ missed dose~~s~~, ~~not taken,~~ incorrect ~~medication taken,~~ doses, ~~overdose occurrence, or side effects observed~~ or adverse side effects; ~~(3-17-22)~~( )

~~vi~~f. ~~Health care professional contacted to determine the level of threat to the individual's health and determine the treatment required, if any; and~~Documentation that a health care professional was contacted for adverse events; and ~~(3-17-22)~~( )

~~vii~~g. Documentation of corrective action ~~taken and results~~ for adverse events or incidents of repeated medication errors. ~~(3-17-22)~~( )

~~g~~05. **Disposal of Medications.** ~~Procedures for~~ Documentation of disposal or destruction of medications ~~must be documented and~~ consistent with procedures outlined in the assistance with medication training course. ~~(3-17-22)~~( )

~~406. GRIEVANCE POLICY.~~
~~Each DDA must develop and implement written grievance policies and procedures that outline in detail the agency's grievance policy. The policy must include how the agency will ensure participant and guardian are aware of the process, how to file a grievance, and receive a response from the agency in fourteen (14) days or less. (3-17-22)~~

40~~7~~6. – 499. (RESERVED)

QUALITY ASSURANCE, ~~PARTICIPANT RIGHTS, REQUIRED POLICIES, ETC~~ BEHAVIOR

MANAGEMENT, AND SPECIFIC PROGRAM REQUIREMENTS.

Sections 500-599

500. REQUIREMENTS FOR AN ~~AGENCY'S~~ ORGANIZATION'S QUALITY ASSURANCE PROGRAM.

Each ~~agency~~ organization must develop and implement a quality assurance program that improves the quality of services, identifies ~~any corrections needed, a time frame for those corrections, and ensures the following:~~ non-compliance or safety issues including corrective measures and timeframes. This review must include; ~~(3-17-22)~~( )

~~**01. Measurable Outcomes**. Produces high quality services that maintain interests, needs, and current standards of practice consistent with individual choices. This includes:~~ ~~(3-17-22)~~

~~a~~**01. ~~Review of p~~Participant ~~r~~Records**~~,~~. ~~for content and effectiveness of programs; and~~ Assess for accurate content and effectiveness of service delivery; ~~(3-17-22)~~( )

~~**b.** A method for gathering and assessing participant satisfaction;~~ ~~(3-17-22)~~

02. ~~Available Personnel and Resources~~Staff Records. ~~Sufficient personnel and material resources are available to meet the needs of each individual served to include a review of:~~ Assess that staff have the necessary skills and training to provide adequate service delivery; and ~~(3-17-22)~~( )

~~**a.** Personnel records for content.~~ ~~(3-17-22)~~

~~**b.** Supervision and training data to ensure there are personnel who have the skills necessary to provide the service.~~ ~~(3-17-22)~~

~~**c.** Work scheduled to assure coverage.~~ ~~(3-17-22)~~

~~**03. Health and Safety Supports**. The overall agency practices are within rule and support participant health and safety to include a review of:~~ ~~(3-17-22)~~

~~**a.** Code of ethics, identification of violations, and implementation of an internal plan of correction;~~ ~~(3-17-22)~~

~~**b**~~**03. Polic~~y~~ies and ~~p~~Procedures**~~. manual to specify date and content of revisions made;~~ Review to ensure content meets the needs of participants served. ~~(3-17-22)~~( )

~~**c.** Center-based facilities, if applicable, to ensure compliance with these rules.~~ ~~(3-17-22)~~

501. --~~504.~~ ~~(RESERVED)~~

~~**505. PARTICIPANT RIGHTS.**~~

~~Each agency must ensure the rights provided under Section 66-412, Idaho Code, as well as the additional rights listed below for each participant receiving DDA services.~~ ~~(3-17-22)~~

~~**01. Participant Rights Provided Under Idaho Code**. Provide the following rights for participants:~~ ~~(3-17-22)~~

~~**a.** Humane care and treatment;~~ ~~(3-17-22)~~

~~**b.** Not be put in isolation;~~ ~~(3-17-22)~~

~~**c.** Be free of restraints, unless necessary for the safety of that individual or for the safety of others;~~ ~~(3-17-22)~~

~~**d.** Be free of mental and physical abuse;~~ ~~(3-17-22)~~

~~e. Voice grievances and recommend changes in policies or services being offered; (3-17-22)~~

~~f. Practice their own religion; (3-17-22)~~

~~g. Wear their own clothing and retain and use personal possessions; (3-17-22)~~

~~h. Be informed of their medical and habilitative condition, of services available at the agency, and the charges for the services; (3-17-22)~~

~~i. Reasonable access to all records concerning themselves; (3-17-22)~~

~~j. Refuse services; (3-17-22)~~

~~k. Exercise all civil and all other rights established by law, unless limited by prior court order; (3-17-22)~~

~~l. Privacy and confidentiality; (3-17-22)~~

~~m. Receive a response from the agency to any request made within fourteen (14) business days; (3-17-22)~~

~~n. Receive services that enhance the participant's social image, personal competencies, and whenever possible, promote inclusion in the community; (3-17-22)~~

~~o. Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law; and (3-17-22)~~

~~p. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction. (3-17-22)~~

~~02. Method of Informing Participants of Their Rights.~~ Each agency must ensure and document that each participant receiving services is informed of their rights in the following manner: ~~(3-17-22)~~

~~a. Upon initiation of services, provide each participant and their parent or guardian, where applicable, with a packet of information that outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet must be written in easily understood terms. (3-17-22)~~

~~b. When providing center-based services, prominently post a list of the rights contained in this chapter. (3-17-22)~~

~~c. Provide each participant and their parent or guardian, where applicable, with a verbal explanation of their rights in a manner that will best promote individual understanding of these rights. (3-17-22)~~

~~506.~~ 509. (RESERVED)

510. ~~POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF RESTRICTIVE INTERVENTIONS~~MANAGING PARTICIPANT BEHAVIOR.

~~Each agency must develop and implement written policies and procedures that address restrictive interventions to include the following:~~The use of systematic interventions to manage inappropriate or maladaptive participant behaviors must follow facility policy and be incorporated into the participant's individual service plan.
~~(3-17-22)~~( )

~~01. Protected Rights.~~ Ensure the safety, welfare, and human and civil rights of participants are adequately protected. ~~(3-17-22)~~

02~~2~~1. ~~Appropriate Use of Interventions~~Techniques to Manage Maladaptive Behavior. ~~Ensure interventions used to manage participants' maladaptive behavior are never~~ Interventions to manage behaviors must never be used: ~~(3-17-22)~~( )

a. For disciplinary purposes; (3-17-22)

b. For the convenience ~~of personnel~~ or lack of staff; or ~~(3-17-22)~~( )

c. As a substitute for ~~a needed training~~ an active treatment program~~; or~~ or needed training. ~~(3-17-22)~~( )

~~**d.** By untrained or unqualified personnel.~~ ~~(3-17-22)~~

03~~2~~. ~~Use of Restraint on Participants~~Physical Restraints and Time Out Requirements. ~~No restraints, other than physical restraint in an emergency, must be used on participants prior to the use of positive behavior interventions. The following requirements apply to the use of physical restraint on participants by qualified personnel.~~ Physical restraints and time out must be: ~~(3-17-22)~~( )

a. ~~Physical restraint may be used in an isolated emergency to prevent injury to the participant or others and must be documented and reviewed by the DSP and the supervisor. Documentation must include a debrief with the participant, guardian, and DSP involved focusing on strategies to avoid the occurrence of future physical restraints.~~Used as an emergency measure when other lesser restrictive interventions have failed and there is substantial risk for harm to self or others; or ~~(3-17-22)~~( )

b. ~~Physical restraint may be used in a non-emergency setting when a written behavior program is developed by a supervisor, the participant, and their guardian, if applicable, and approved by a health care professional. Informed consent is required by the participant and parent or legal guardian~~Part of an integral service plan that is intended to lead to less restrictive means of managing or eliminating the behavior for which the restraint is applied. ~~(3-17-22)~~( )

c. Utilized by staff that have been certified in a nationally recognized behavior management program approved by the Department. ( )

d. Used only until the participant has regained control. ( )

e. Documented in the participant record including date, time, duration, staff involved and description of behaviors. ( )

04~~3~~. Written Informed Consent. ~~If the program contains restrictive or aversive components, an individual working within the scope of their license or certification must also review and approve, in writing, the plan prior to implementation. The participant, parent or legal guardian, if applicable, must also consent prior to implementation. When programs implemented by the agency are developed by another service provider, the agency must obtain a copy of these reviews and approvals~~ If an organization uses physical restraints as part of their behavior management program, participants, and their legal guardian, if applicable, must provide written informed consent. ~~(3-17-22)~~( )

511. STANDARDS FOR A DDA CENTER AND ADULT RESIDENTIAL CARE FACILITY.

01. Environment. The facility must be designed and equipped to meet the needs of each participant including sufficient space, adaptive equipment, lighting, and noise control. Facilities providing residential care must provide participants with sleeping rooms including furnishings, such as a dresser and bed, and be safe and in good repair. ( )

02. Construction Changes. For changes of occupancy, modifications, additions, or renovations to existing buildings, the facility must submit certificate of occupancy to the Department for approval prior to admitting participants. ( )

03. Fire Safety Standards. Locations must maintain the following records: ( )

a. A copy of an annual local fire authority inspection including any necessary corrective actions; ( )

b. Documentation of quarterly fire drills, including date, time, duration, names of participants and staff involved, and any resulting corrective action(s); and ( )

c. Documentation that at least two (2) times each year fire drills included a complete evacuation of the building. ( )

04. Environment Safety Standards. ( )

a. Provide fences, guards, or railings to protect participants on the premises where natural or man-made hazards are present; ( )

b. Portable heating devices must be approved by the local fire authority; ( )

c. Properly label and store all hazardous or toxic substances under lock and key; ( )

d. Maintain water temperatures in areas accessed by participants at one hundred twenty degrees Fahrenheit (120°F) or below; ( )

e. Have a telephone on the premises with emergency numbers available; and ( )

f. Evacuation plans must be posted throughout the center and indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of the building. ( )

05. Food Safety and Nutrition. ( )

a. Organizations that provide food services must: ( )

i. Meet the standards in IDAPA 16.02.19, "Idaho Food Code." Compliance is verified through inspection by the local District Health Department. ( )

ii. Provide three (3) daily balanced meals in appropriate intervals. ( )

iii. Menu must be planned, approved, signed and dated by a registered dietician. Menus must be maintained on file for sixty (60) days and include any substitutions. ( )

iv. Accommodations must be made to a participant with special medical or religious dietary needs. ( )

b. Refrigerators and freezers used to store participant foods will be maintained at or below forty-one degrees Fahrenheit (41°F), and ten degrees Fahrenheit (10°F) respectively; and ( )

c. When medicines requiring refrigeration are stored in a food refrigerator, medicines must be stored in a package and kept inside a covered, leak-proof container that is identified as a container for the storage of medicines. ( )

06. Housekeeping and Maintenance Services. The organization must meet the following: ( )

a. The center must be clean, safe, and kept in good repair; ( )

b. Ensure the building is free from infestations of insects, rodents, and other pests; and ( )

c. Maintain the temperature and humidity of the building within a normal comfort range by heating,

air conditioning, or other means. ( )

512. RESIDENTIAL HABILITATION AGENCIES TERMINATION PROCEDURES.

01. Emergency Termination. Emergency conditions warranting immediate termination of services include: ( )

a. A change in the participant's condition resulting in an increased level of care beyond the scope of the organization's ability to provide care for the participant; or ( )

b. Significant behavior concerns including physical aggression by the participant that puts the health and safety of the organization's staff or other participants in jeopardy and behavior management techniques have failed to reduce the risk to staff or others. ( )

02. Termination with Notice. The organization must provide written notice of no less than thirty (30) days for termination, include a transition plan, and a copy of the organization grievance policy. A transition plan is an interim plan defining activities to facilitate the transition out of residential habilitation services. ( )

03. Termination with Agreement. Services may be terminated prior to thirty (30) days if both parties agree in writing. ( )

511~~1~~3. -- 599. (RESERVED)

**RULE ENFORCEMENT PROCESS AND REMEDIES
SECTIONS 600-699**

600. ENFORCEMENT PROCESS.
The Department may impose ~~a remedy~~ an enforcement action when it determines an ~~agency has not met the requirements in these rules~~ organization is not in compliance with these rules. The Department may monitor the organization on an as-needed basis, until it has been established the organization is in substantial compliance. ~~(3-17-22)~~( )

01. Determination of Remedy. In determining which remedy to impose, the Department will consider the ~~agency's~~ organization's compliance history, change of ownership, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to participants. Subject to these considerations, any one or combination of the following remedies, is subject under these rules for notice and appeal: ~~(3-17-22)~~( )

a. Require the ~~agency~~ organization to submit a plan of correction approved ~~in writing~~ by the Department; ~~(3-17-22)~~( )

b. Issue a provisional certificate ~~with a specific date for correcting deficient practices~~; ~~(3-17-22)~~ _

~~**c.** Ban enrollment of all participants with specified diagnoses; (3-17-22)~~

~~**d**~~**c.** Ban ~~any~~ new enrollment of participants; ~~(3-17-22)~~( )

~~**e**~~**d.** Summarily suspend the certificate and transfer participants; or (3-17-22)

~~**f**~~**e.** Revoke the ~~agency's~~ organization's certificate. ~~(3-17-22)~~( )

02. Immediate Jeopardy. If ~~the Department finds~~ it is determined an ~~agency's deficiency~~ organization's non-compliance with these rules immediately jeopardizes the health or safety of ~~its~~ a participant~~s~~, the ~~Department may~~ certificate may be summarily suspend ~~the agency's certificate~~ed. ~~(3-17-22)~~( )

03. Repeat Deficiency. ~~If the Department finds a repeat deficiency in an agency, it may impose any of the remedies listed in Subsection 600.01 of this rule, The Department may monitor the agency on an as-needed basis, until the agency has demonstrated to the Department's satisfaction that it is in compliance with these rules. If so, then~~

~~certification will be granted. If not, the certificate will be denied or revoked~~ A Repeat deficiency may result in any of the remedies listed in this section. ~~(3-17-22)~~( )

04. Failure to Comply. The Department may impose one (1) or more of the remedies specified in ~~Subsection 600.01 of this rule if~~ this section~~:~~ ~~(3-17-22)~~

~~**a.** The~~ if the ~~agency~~ organization has not ~~complied with any requirement in these rules~~ returned to compliance within three (3) months ~~after the date it was notified of its failure to comply with such requirement; or~~ of implementing a plan of correction. ~~(3-17-22)~~( )

~~**b.** The agency has failed to correct the deficiencies stated in the agency's accepted plan of correction and as verified by the Department, via resurveys.~~ ~~(3-17-22)~~

601. REVOCATION OF CERTIFICATE.

01. Revocation of the ~~Agency's~~ Organizations Certificate. The Department may revoke a ~~agency's~~ certificate when ~~persuaded by the preponderance of the evidence that~~ the ~~agency~~ organization is not in substantial compliance with the requirements ~~in these rules. The certificate is the property of the state and must be returned to the state if it is revoked or suspended~~. ~~(3-17-22)~~( )

02. Causes for Revocation of the Certificate. The Department may revoke any ~~agency's~~ organization's certificate for any of the following causes: ~~(3-17-22)~~( )

a. The certificate holder has willfully misrepresented or omitted information on the application for certification or other documents pertinent to obtaining a certificate; (3-17-22)

b. Conditions exist in the ~~agency~~ organization that endanger the health or safety of any participant; ~~(3-17-22)~~( )

c. Any act adversely affecting the welfare of participants is being permitted, performed, or aided and abetted by the person(s) supervising the provision of services in the ~~agency~~ organization. Such acts include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; ~~(3-17-22)~~( )

~~**d.** The provider has demonstrated or exhibited a lack of sound judgment that jeopardizes the health, safety, or well-being of participants;~~ ~~(3-17-22)~~

~~**e**~~**d.** The ~~agency~~ organization has failed to comply with any of the conditions of a provisional certificate; ~~(3-17-22)~~( )

~~**f.** The agency has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health, safety, or welfare of any participant;~~ ~~(3-17-22)~~

~~**g.** An accumulation of minor deficiencies that, when considered as a whole, indicate the agency is not in substantial compliance with these rules;~~ ~~(3-17-22)~~

~~**h.** Repeat deficiencies by the agency of any requirement of these rules or of the Idaho Code;~~ ~~(3-17-22)~~

~~**i**~~**c.** The ~~agency~~ organization lacks adequate ~~personnel~~ staff, as required by these rules or as directed by the Department, to properly care for the number and type of participants served at the ~~agency~~ organization; or ~~(3-17-22)~~( )

~~**j.** The agency is not in substantial compliance with the provisions for services required in these rules or with the participants' rights under Section 505 of these rules;~~ ~~(3-17-22)~~

~~**k**~~**f.** The certificate holder refuses to allow the Department or protection and advocacy agencies full access to the ~~agency~~ organization environment, ~~agency~~ organization records, or the participants. ~~(3-17-22)~~( )

~~**602. NOTICE OF ENFORCEMENT REMEDY.**~~
~~The Department will notify the following of the imposition of any enforcement remedy on a agency:~~ ~~(3-17-22)~~

~~**01. Notice to Agency**. The Department will notify the agency in writing, transmitted in a manner that will reasonably ensure timely receipt.~~ ~~(3-17-22)~~

~~**02. Notice to Public**. The Department will notify the public by sending the agency printed notices to post. The agency must post all the notices on the premises of the agency in plain sight in public areas where they will readily be seen by participants and their representatives, including exits and common areas and with the notices remaining in place until all enforcement remedies have been officially removed by the Department.~~ ~~(3-17-22)~~

602. INJUNCTION TO PREVENT OPERATION WITHOUT CERTIFICATE.
Notwithstanding the existence or pursuit of any other remedy, the Department may in the manner provided by law, maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of an organization without a certificate required under this chapter. For the purposes of these rules, a governmental unit is the state, or any county, municipality, or other political subdivision, or any department, division, board, or other organization thereof. ( )

603. WAIVERS.
Waivers to these rules may be granted through the Department-approved process under Section 67-5230, Idaho Code. ( )

60~~3~~4. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.22 – RESIDENTIAL ASSISTED LIVING FACILITIES

DOCKET NO. 16-0322-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-3305 and 39-3358, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 9, 2025 **1:00 PM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mfa92068288da5b29e04435961568c15d** **Join by meeting number** **Meeting number (access code): 2829 726 2075** **Meeting password: wqHuAZ3Su55** **Meeting password when dialing from a phone or video system: 97482937** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Friday, June 20, 2025 **9:30 AM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m2f4078949547e149eb63e486e59c8c76** **Join by meeting number** **Meeting number (access code): 2824 243 4131** **Meeting password:dHMPGuh7i22** **Meeting password when dialing from a phone or video system: 34674847** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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

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

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

SB 1102 passed by the 2025 Idaho Legislature revoked certain provisions contained in IDAPA 16.03.22, declaring them null, void, and of no force and effect. This ZBR Chapter Rewrite reflects amendments to codified text as it will look on July, 1, 2025, when the enacted legislation will become law, and not the rule chapter as it is currently enforceable. To view the official text of IDAPA 16.03.22 as it is currently effective, click here.

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

Fees will not be increased as a result of this rulemaking.

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

There is not anticipated to be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, Volume 25-4, pages 25 and 26.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25th, 2025.

DATED this 2nd day of May, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
DHWRules@dhw.idaho.gov

16.03.22 – RESIDENTIAL ASSISTED LIVING FACILITIES

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Sections 39-3305 and 39-3358, Idaho Code, to adopt and enforce rules to protect the health, safety, and individual rights for residents in residential assisted living facilities.
(3-15-22)

001. ~~TITLE,~~ SCOPE~~, AND RESPONSIBILITIES~~.

~~01.~~ ~~Title~~. ~~The title of this chapter of rules is IDAPA 16.03.22, "Residential Assisted Living Facilities."~~ ~~(3-15-22)~~

~~02.~~ ~~Scope~~. ~~The purpose of a residential assisted living facility is to provide choice, dignity, and independence to residents while maintaining a safe, humane, and home-like living arrangement for individuals needing assistance with daily activities and personal care.~~ These rules set standards for providing services that maintain a safe and healthy environment for residential assisted living facilities.. ~~(3-15-22)~~( )

~~03.~~ ~~General Provider Responsibilities~~. ~~The facility must ensure quality services by providing choices, dignity, and independence to residents. The facility must have an administrator and staff who have the knowledge and experience required to provide safe and appropriate services to all residents of the facility. The facility must be operated consistent with the rules and statutes as it conducts its work.~~ ~~(3-15-22)~~

~~04.~~ ~~General Department Responsibilities~~. ~~The Department is responsible for monitoring and enforcing the provisions of the statute and this chapter to protect residents in these facilities by providing information, education, and evaluating providers to ensure compliance with statute and these rules. This responsibility includes licensing facilities and monitoring the condition of facilities.~~ ~~(3-15-22)~~

~~002. WRITTEN INTERPRETATIONS.~~
~~This agency has written statements which pertain to the interpretations of the rules of this chapter or to the documentation of compliance with the rules of this chapter. These documents are available for public inspection on the program website http://assistedliving.dhw.idaho.gov.~~ ~~(3-15-22)~~

~~003. ADMINISTRATIVE APPEALS AND CONTESTED CASES.~~
~~Administrative appeals and contested cases are governed by IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."~~ ~~(3-15-22)~~

~~004. INCORPORATION BY REFERENCE.~~
~~The documents referenced in this rule, are incorporated by reference as provided by Section 67-5229(a), Idaho Code. These incorporated documents are available for public review upon request at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702, or when available online at the websites provided in these rules.~~
~~(3-15-22)~~

~~01.~~ ~~National Fire Protection Association (NFPA) Documents~~. ~~(3-15-22)~~

~~a.~~ ~~National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, 2018 Edition, the occupancy chapters and all mandatory referenced documents contained therein under "Mandatory References."~~
~~(3-15-22)~~

~~b.~~ ~~National Fire Protection Association (NFPA) Standard 99, Health Care Facilities Code, 2018 Edition.~~ ~~(3-15-22)~~

~~02.~~ ~~Idaho Diet Manual~~. ~~The manual is available from the Idaho Academy of Nutrition & Dietetics, Eleventh Edition, 2015, online at http://eatrightidaho.org.~~ ~~(3-15-22)~~

~~03.~~ ~~Idaho Food Code~~. ~~IDAPA 16.02.19, "Idaho Food Code." These rules are available online at http://adminrules.idaho.gov/rules/current/16/160219.pdf.~~ ~~(3-15-22)~~

~~04.~~ ~~Americans with Disabilities Act Accessibility Guidelines~~. ~~28 CFR Part 36, Appendix A. This code is available online at http://www.ada.gov/1991standards/adastd94-archive.pdf.~~ ~~(3-15-22)~~

~~05.~~ ~~Idaho Board of Nursing Rules~~. ~~IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." These rules are available online at https://adminrules.idaho.gov/rules/current/24/243401.pdf.~~ ~~(3-15-22)~~

~~06.~~ ~~International Building Code~~. ~~IDAPA 24.39.30, "Rules of Building Safety." These rules are~~

~~available online at https://adminrules.idaho.gov/rules/current/24/243930.pdf.~~ ~~(3-15-22)~~

00~~5~~2. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. A residential assisted living facility must complete a criminal history and background check on employees and contractors ~~hired or contracted with after October 1, 2005~~, who have direct resident access to residents in the residential assisted living facility. The Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. ~~Other criminal history and background checks may be acceptable provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee.~~ ~~(3-15-22)~~( )

~~**02. Scope of a Criminal History and Background Check**. The criminal history and background check must, at a minimum, be fingerprint-based and include a search of the following record sources:~~ ~~(3-15-22)~~

~~**a.** Federal Bureau of Investigation (FBI);~~ ~~(3-15-22)~~

~~**b.** Idaho State Police Bureau of Criminal Identification;~~ ~~(3-15-22)~~

~~**c.** Sexual Offender Registry;~~ ~~(3-15-22)~~

~~**d.** Office of Inspector General List of Excluded Individuals and Entities; and~~ ~~(3-15-22)~~

~~**e.** Nurse Aide Registry.~~ ~~(3-15-22)~~

~~**03. Availability to Work**. Any direct resident access individual hired or contracted with on or after October 1, 2005, must self-disclose all arrests and convictions before having access to residents.~~ ~~(3-15-22)~~

a. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual must not have direct resident access to any resident. (3-15-22)

b. The individual is only allowed to work under another employee who has a cleared criminal history and background check ~~that meets the criteria in this rule. The cleared employee must keep the individual waiting for clearance in line-of-sight when the individual has direct resident access until the criminal history and background check is completed and the results are obtained by the facility, unless:~~ while waiting for results. The unlicensed employee may not have one-to-one contact with a resident or access their personal belongings without the supervision of a cleared employee. ~~(3-15-22)~~( )

~~i. The individual has completed an alternative criminal history and background check that includes a search of the record sources listed in Subsection 009.02 except for Subsection 009.02.a. in this rule;~~ ~~(3-15-22)~~

~~ii. The facility determines there is no potential danger to residents; and~~ ~~(3-15-22)~~

~~iii. This alternative criminal history and background check is only in effect until the required criminal history and background check that meets the criteria in this rule is completed. The results must state whether the individual was cleared or denied based on the completed fingerprint-based background check.~~ ~~(3-15-22)~~

~~**04. Submission of Fingerprints**. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of their date of hire.~~ ~~(3-15-22)~~

~~**05. New Criminal History and Background Check**. An individual must have a criminal history and background check when:~~ ~~(3-15-22)~~

~~**a.** Accepting employment with a new employer; and~~ ~~(3-15-22)~~

~~**b.** The individual's last criminal history and background check was completed more than three (3) years prior to their date of hire. (3-15-22)~~

~~**06. Use of Previous Criminal History and Background Check**. Any employer is allowed to use a previous criminal history and background check that meets the criteria in this rule if: (3-15-22)~~

~~**a.** The individual has received a criminal history and background check within three (3) years of their date of hire; (3-15-22)~~

~~**b.** Prior to the individual being granted unsupervised direct resident access, the employer obtains and retains the individual's previous criminal history and background check results; (3-15-22)~~

~~**c.** The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, within thirty (30) days of obtaining the previous criminal history and background check results; and (3-15-22)~~

~~**d.** No disqualifying crimes are found. (3-15-22)~~

~~**07. Employer Discretion**. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within three (3) years of their date of hire. (3-15-22)~~

010. DEFINITIONS AND ABBREVIATIONS ~~A THROUGH E~~.

~~**01. Abuse**. A non-accidental act of sexual, physical, or mental mistreatment or injury of a resident through the action or inaction of another individual. (3-15-22)~~

~~**02. Accident**. An unexpected, unintended event that can cause a resident injury. (3-15-22)~~

~~**03. Activities**. All organized and directed social and rehabilitative services a facility provides, arranges, or cooperates with. (3-15-22)~~

~~**04. Activities of Daily Living**. Self-care actions necessary to sustain an individual in daily living, including bathing, dressing, toileting, grooming, eating, communicating, and managing medications. (3-15-22)~~

~~**05. Administrator**. An individual licensed by the Idaho Bureau of Occupational Licenses as a Residential Assisted Living Facility Administrator. (3-15-22)~~

~~**06. Administrator's Designee**. A person authorized in writing to act in the absence of the administrator who is knowledgeable of facility operations, the residents and their needs, emergency procedures, the location and operation of emergency equipment, and how the administrator can be reached in the event of an emergency. (3-15-22)~~

~~**07. Adult**. A person who has reached eighteen (18) years of age. (3-15-22)~~

0~~8~~1. **Advance Directive**. A written instruction, such as a living will or durable power of attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the State, related to the provision of medical care when the individual is unable to communicate. (3-15-22)

~~**09. Advocate**. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a population group served by a facility. (3-15-22)~~

~~**10. Ambulatory Person**. A person who, unaided by any other person, is physically and mentally capable of walking a normal path to safety, including the ascent and descent of stairs. (3-15-22)~~

~~**11. Assessment**. Information gathered that identifies resident strengths, weaknesses, risks, and needs, to include functional, social, medical, and behavioral needs. (3-15-22)~~

~~12. Authentication. The process or action of proving or showing authorship to be true, genuine, or valid.~~ ~~(3-15-22)~~

~~13. Authorized Provider. An individual who is a nurse practitioner, clinical nurse specialist, or physician assistant.~~ ~~(3-15-22)~~

~~14~~02. **Behavior Plan**. A ~~written plan that decreases the frequency, duration, or intensity of maladaptive behaviors, and increases the frequency of adaptive behaviors~~ person-centered document outlining strategies to address and modify a specific behavior, developed based on a functional assessment that identifies the underlying cause of the behavior, and includes proactive steps to prevent the behavior, teach alternate appropriate behaviors, and provide reinforcement for positive interactions. ~~(3-15-22)~~( )

~~15~~03. **Call System**. A signaling system whereby a resident can contact staff directly from their sleeping room, toilet room, and bathing area. ~~The system may be voice communication, or an audible or visual signal, and may include wireless technology.~~ The call system cannot be configured in such a way as to breach a resident's right to privacy at the facility, including in the resident's living quarters, in common areas, during medical treatments, while receiving other services, in written and telephonic communications, or in visits with family, friends, advocates, and resident groups. ~~(3-15-22)~~( )

~~16. Chemical Restraint. A medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the resident's condition.~~ ~~(3-15-22)~~

~~17~~04. **Cognitive Impairment**. When a person experiences loss of short or long-term memory, orientation to person, place, or time, safety awareness, or loses the ability to make decisions that affect everyday life. (3-15-22)

~~18. Complaint. A formal expression of dissatisfaction, discontent, or unhappiness by, or on behalf of, a resident concerning the care or conditions at the facility. This expression could be oral, in writing, or by alternative means of communication.~~ ~~(3-15-22)~~

~~19~~05. **Complaint Investigation**. A survey to investigate the validity of allegations of noncompliance with applicable state requirements. Allegations will be investigated by the Licensing Agency as described in Section 39-3355, Idaho Code. (3-15-22)

~~20. Core Issue. A core issue is any one (1) of the following:~~ ~~(3-15-22)~~

~~a. Abuse;~~ ~~(3-15-22)~~

~~b. Neglect;~~ ~~(3-15-22)~~

~~c. Exploitation;~~ ~~(3-15-22)~~

~~d. Inadequate care;~~ ~~(3-15-22)~~

~~e. A situation in which the facility has operated for more than thirty (30) days without a licensed administrator overseeing the day-to-day operations of the facility;~~ ~~(3-15-22)~~

~~f. Inoperable fire detection or extinguishing systems with no fire watch in place pending the correction of the system; or~~ ~~(3-15-22)~~

~~g. Surveyors denied access to records, residents, or facilities.~~ ~~(3-15-22)~~

~~21~~06. **Criminal Offense**. Any crime as defined in Section 18-111, Idaho Code, 18 U.S.C. Section 4B1.2(a), and 18 U.S.C. Sections 1001 through 1027. (3-15-22)

~~22. Deficiency. A determination of noncompliance with a specific rule or part of a rule.~~ ~~(3-15-22)~~

~~23~~07. **Dementia**. A chronic deterioration of intellectual function and other cognitive skills severe enough to interfere with the ability to perform activities of daily living. (3-15-22)

~~24. **Department**. The Idaho Department of Health and Welfare.~~ ~~(3-15-22)~~

~~25~~08. **Developmental Disability**. A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person which appears before twenty-two (22) years of age ~~and:~~. ~~(3-15-22)~~( )

~~a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism, or other conditions found to be closely related or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments;~~ ~~(3-15-22)~~

~~b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and~~ ~~(3-15-22)~~

~~c. Reflects the need for a combination and sequence of special, interdisciplinary or direct care, treatment, or other services which are of life-long or extended duration, and individually planned and coordinated.~~ ~~(3-15-22)~~

~~26~~09. **Direct Resident Access**. In-person access with any resident who resides at the facility, or any access to the residents' personal belongings or information. (3-15-22)

~~27. **Director**. The Director of the Idaho Department of Health and Welfare or their designee.~~ ~~(3-15-22)~~

~~28. **Electronic Signature**. The system for signing electronic documents by entering a unique code or password that verifies the identity of the person signing and creates an individual "signature" on the record.~~ ~~(3-15-22)~~

~~29~~10. **Elopement**. When a resident who is cognitively, physically, mentally, emotionally, or chemically impaired, physically leaves the facility ~~premises~~ property or the secured unit or yard without personnel's knowledge. ~~(3-15-22)~~( )

~~30. **Exit Conference**. A meeting with the facility administrator or designee to: (1) provide review, discussion, and written documentation of non-core issues, and (2) to provide preliminary findings of core issues.~~ ~~(3-15-22)~~

~~31. **Exploitation**. The misuse of a resident's funds, property, resources, identity, or person for profit or advantage. This includes charging a resident for services or supplies not provided or disclosed in the written admission agreement and staff accepting gifts or money for extra services.~~ ~~(3-15-22)~~

~~011. DEFINITIONS AND ABBREVIATIONS F THROUGH N.~~

~~01. **Follow-Up Survey**. A survey conducted to confirm that the facility is in compliance and has the ability to remain in compliance.~~ ~~(3-15-22)~~

~~02. **Governmental Unit**. The state, any county, any city, or any department, division, board, or other agency.~~ ~~(3-15-22)~~

~~03~~11. **Hourly Adult Care**. Nonresident daily services and supervision provided by a facility to individuals who are in need of supervision outside of their personal residence(s) for a portion of the day. (3-15-22)

~~04. **Immediate Danger**. Any resident is subject to an imminent or substantial danger.~~ ~~(3-15-22)~~

~~05. **Inadequate Care**. When a facility fails to provide the services required to meet the terms of the Negotiated Service Agreement, or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services, a safe living environment,~~

~~engages in violations of resident rights, or takes residents who have been admitted in violation of the provisions of Section 152 of these rules.~~ ~~(3-15-22)~~

~~06~~12. **Incident**. An event that can cause a resident injury. (3-15-22)

~~07. **Independent Mobility**. A person's ability to move about freely of their own choice with or without the assistance of a mobility device such as a wheelchair, cane, crutches, or walker.~~ ~~(3-15-22)~~

~~08~~13. **Legal Guardian or Conservator**. A court-appointed individual designated to manage the affairs or finances of another person who has been found to be incapable of handling their own affairs. (3-15-22)

~~09. **License**. A permit to operate a residential assisted living facility.~~ ~~(3-15-22)~~

~~10. **Licensing Agency**. The Residential Assisted Living Facilities Program, a unit of the Division of Licensing and Certification within the Department of Health and Welfare, that conducts inspections and surveys of residential assisted living facilities and issues licenses based on compliance with this chapter of rules, in which "Residential Assisted Living Facilities Program" and "Licensing Agency" are synonymous.~~ ~~(3-15-22)~~

1~~1~~4. **Maladaptive Behavior**. Any behavior that ~~interferes with resident care,~~ infringes on any resident's rights, or presents a danger to the resident or others. ~~Involuntary muscle movements are not considered maladaptive behaviors~~. ~~(3-15-22)~~( )

1~~2~~5. **Medication**. Any substance used to treat a disease, condition, or symptom, which may be taken orally, injected, or used externally, and is available through prescription or over-the-counter. (3-15-22)

1~~3~~6. **Medication Administration**. The process where a prescribed medication is given by a licensed nurse to a resident ~~through one (1) of several routes~~. ~~(3-15-22)~~( )

1~~4~~7. **Medication Assistance**. The process whereby a non-licensed care provider is delegated tasks by a licensed nurse, to aid a person who cannot independently self-administer medications. ~~See IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," Section 010.~~ ~~(3-15-22)~~( )

1~~5~~8. **Mental Disorders**. Health conditions that are characterized by alterations in thinking, mood, behavior, or some combination thereof, that are all mediated by the brain and associated with distress or impaired functioning. (3-15-22)

1~~6~~9. **Mental Illness**. Refers collectively to all diagnosable mental disorders. (3-15-22)

~~17. **Neglect**. Failure to provide food, clothing, shelter, or medical care necessary to sustain the life and health of a resident.~~ ~~(3-15-22)~~

~~18. **Negotiated Service Agreement**. The plan reached by the resident or their representative and the facility which outlines services to be provided and the obligations of the facility and the resident.~~ ~~(3-15-22)~~

~~19. **Non-Core Issue**. Any finding of deficient practice that is not a core issue.~~ ~~(3-15-22)~~

20. **Nursing Assessment**. Information gathered related to a resident's health or medical status that has been reviewed, signed, and dated by a licensed ~~registered~~ nurse~~, as described in Section 305 of these rules~~. ~~(3-15-22)~~( )

~~012. DEFINITIONS AND ABBREVIATIONS O THROUGH Z.~~

~~01~~21. **Outside Services**. Services provided to a resident by someone that is not a member of facility personnel. (3-15-22)

~~02~~22. **Owner**. Any person or entity having legal ownership of the facility as an operating business, regardless of who owns the real property. (3-15-22)

~~03. Personal Assistance. The provision by the staff of the facility of one (1) or more of the following services: (3-15-22)~~

~~a. Assisting the resident with activities of daily living; (3-15-22)~~

~~b. Arranging for outside services; (3-15-22)~~

~~c. Being aware of the resident's general whereabouts; or (3-15-22)~~

~~d. Monitoring the activities of the resident while on the premises of the facility to ensure the resident's health, safety, and well-being. (3-15-22)~~

~~04~~23. **Personnel**. Paid individuals assigned the responsibility of providing care, supervision, and services to the facility and its residents. In this chapter of rules, "personnel" and "staff" are synonymous. (3-15-22)

~~05. Physical Restraint. Any device or physical force that restricts the free movement of, normal functioning of, or normal access to, a portion or portions of an individual's body, except for the temporary treatment of a medical condition, such as the use of a cast for a broken bone. (3-15-22)~~

~~06~~24. **Portable Heating Device**. Any device designed to provide heat on a temporary basis that is not designed as part of a building's heating system, is not permanently affixed to the building, and, if electrical, is not hardwired to the building's electrical service. This does not include the use of therapeutic devices such as heating pads, heated mattress pads, and electric blankets, which require a physician or authorized provider's order. (3-15-22)

~~07~~25. **PRN**. Indicates that a medication or treatment prescribed by a medical professional to an individual may be given as needed. (3-15-22)

~~08. Pressure Injury. Any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). (3-15-22)~~

~~09~~26. **Provisional License**. A license which may be issued to a facility not in compliance with the rules pending the satisfactory correction of all deficiencies. (3-15-22)

~~10~~27. **Publicly Funded Program**. Any program funded in whole, or in part, by an appropriation of the U.S. Congress, the Idaho Legislature, or other governmental body. (3-15-22)

~~11~~28. **Punishment**. The use of an adverse consequence with a resident, the administration of any noxious or unpleasant stimulus, or deprivation of a resident's rights or freedom. (3-15-22)

~~12~~29. **Relative**. A person related by birth, adoption, or marriage. (3-15-22)

~~13~~30. **Repeat Deficiency**. A deficiency found on a licensure survey, complaint investigation, or follow-up survey that was also found on the previous survey. (3-15-22)

~~14~~31. **Reportable Incident**. A situation when a facility is required to report information to the Residential Assisted Living Facilities Program, including: (3-15-22)

~~a. Any resident injury of unknown origin (i.e., an injury, the source of which was not observed by any person and could not be explained by the resident); (3-15-22)~~

~~b~~a. Any resident injury of significant or suspicious nature (i.e., an injury that includes severe bruising, fingerprint bruises, laceration(s) larger than a minor skin tear, sprains, or fractured bones); (3-15-22)

~~c. Resident injury resulting from accidents involving facility-sponsored transportation (i.e., falling from the facility's van lift, a wheelchair belt coming loose during transport, or a collision); (3-15-22)~~

~~d~~b. Resident elopement of any duration; (3-15-22)

~~e~~c. Any significant injury resulting from a resident-to-resident incident; ~~(3-15-22)~~( )

~~f~~d. An incident that results in the resident's need for assessment or treatment ~~outside of the facility~~ at a hospital; or ~~(3-15-22)~~( )

~~g~~e. An incident that results in the resident's death. (3-15-22)

~~15. Resident. An adult, other than the owner, administrator, their immediate families, or employees, who lives in a residential assisted living facility.~~ ~~(3-15-22)~~

~~16. Residential Assisted Living Facility. A facility or residence, however named, licensed in the state of Idaho, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner.~~ ~~(3-15-22)~~

~~17. Room and Board. Lodging, meals, and utilities.~~ ~~(3-15-22)~~

~~18~~32. **Scope**. The frequency or extent of the occurrence of a deficiency in a facility. (3-15-22)

~~19~~33. **Self-Administration of Medication**. The act of a resident taking a single dose of their own medication from a properly labeled container and placing it internally in, or externally on, their own body as a result of an order by an authorized provider. (3-15-22)

~~20. Story. A level of rooms in a building.~~ ~~(3-15-22)~~

~~21. Substantial Compliance. The status of a facility that has no core issue deficiencies.~~ ~~(3-15-22)~~

~~22. Substantial Evening Meal. An offering of three (3) or more menu items at one time, one (1) of which is a high-quality protein such as meat, fish, eggs, or cheeses. The meal should represent no less than twenty percent (20%) of the day's total nutritional requirements.~~ ~~(3-15-22)~~

~~23. Supervision. A critical watching and directing activity which provides protection, guidance, knowledge of the resident's general whereabouts, and assistance with activities of daily living. The administrator is responsible for providing appropriate supervision based on each resident's Negotiated Service Agreement or other legal requirements.~~ ~~(3-15-22)~~

~~24~~34. **Survey**. A review conducted by a surveyor to determine compliance with statutes and rules. ~~There are two (2) components to a survey: (1) health care and (2) fire, life, and safety.~~ ~~(3-15-22)~~( )

~~25~~35. **Surveyor**. A person authorized by the Department to conduct surveys or complaint investigations to determine compliance with statutes and rules. (3-15-22)

~~26~~36. **Therapeutic Diet**. A diet ordered by a physician or authorized provider as part of treatment for a clinical condition or disease~~, to eliminate or decrease specific nutrients in the diet (e.g., sodium), to increase specific nutrients in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet)~~. ~~(3-15-22)~~( )

~~27~~37. **Toxic Chemical**. A substance that is hazardous to health if inhaled, ingested, or absorbed through skin. (3-15-22)

~~28~~38. **Traumatic Brain Injury (TBI)**. An acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment. The term applies to open or closed-head injuries resulting in impairments in one (1) or more areas. (3-15-22)

~~29~~39. **Unlicensed Assistive Personnel (UAP)**. Staff, with or without formal credentials, employed to perform nursing care services under the direction and supervision of licensed nurses. (3-15-22)

~~30~~40. **Variance**. Permission by the Department to do something contrary to rule. (3-15-22)

01~~3~~1. -- 049. (RESERVED)

050. VARIANCES.

The Licensing Agency may grant a variance ~~provided the following criteria are met~~ to a rule provided the written requests meet the requirements under Title 67 Chapter 52, Idaho Code. ~~(3-15-22)~~( )

~~01. Written Request. A written request for a variance must be sent to the Licensing Agency. The request must include the following:~~ ~~(3-15-22)~~

~~a. Reference to the rule for which the variance is requested;~~ ~~(3-15-22)~~

~~b. Reasons that show good cause why the variance should be granted, the extenuating circumstances which caused the need for the variance, any compensating factors or conditions that may have bearing on the variance such as additional floor space or additional staffing; and~~ ~~(3-15-22)~~

~~c. Written documentation that ensures residents' health and safety will not be jeopardized if a variance is granted.~~ ~~(3-15-22)~~

0~~2~~1. **Temporary Variance**. A temporary variance may be granted for a specific resident or situation. ~~The variance expires when the resident no longer lives at the facility or when the situation no longer exists.~~ ~~(3-15-22)~~( )

0~~3~~2. **Continuing A Variance**. The Licensing Agency reviews the appropriateness of continuing a variance during the survey process. ~~If the facility administrator wishes to continue the variance, an annual request must be submitted to the Licensing Agency in writing.~~ ~~(3-15-22)~~( )

~~04. Decision to Grant a Variance. The decision to grant a variance will not be considered as a precedent or be given any force or effect in any other proceeding.~~ ~~(3-15-22)~~

0~~5~~3. **Revocation of Variance**. The Licensing Agency may revoke a variance if circumstances identify a risk to resident health and safety. ~~(3-15-22)~~( )

051. -- 099. (RESERVED)

100. LICENSING REQUIREMENTS.

~~01. Current License. No person, firm, partnership, association, corporation, or governmental unit can operate, establish, manage, conduct, or maintain a residential assisted living facility in Idaho without a license issued by the Department as required in Section 39-3340, Idaho Code. Any entity found operating as a residential assisted living facility without a license is subject to Section 39-3352, Idaho Code.~~ ~~(3-15-22)~~

0~~2~~1. **Issuance of License**. ~~Upon completion of the application process requirements, the Department will issue a residential assisted living facility license~~ A license will be issued to any organization upon completing an application demonstrating compliance with these rules. ~~(3-15-22)~~( )

0~~3~~2. **Distinctive Business Name**. Every facility must use a distinctive name, which is registered with the Idaho Secretary of State. ~~If a facility decides to change its name, it will only be changed upon written notification to the Licensing Agency confirming the registration of the name change with the Idaho Secretary of State. This notification needs to be received by the Licensing Agency at least thirty (30) calendar days prior to the date the proposed name change is to be effective~~ The facility will notify the Department within thirty (30) calendar days of a registered name change. ~~(3-15-22)~~( )

~~04. Administrator. Each facility must have an administrator.~~ ~~(3-15-22)~~

053. Display of Facility License. The current facility license must be posted in the facility and clearly visible to the general public. (3-15-22)

~~**06. Change in Corporate Shares**. When there is a significant change in shares held by a corporate licensee of a residential assisted living facility, which does not alter the overall ownership or operation of the business, that change must be communicated to the Licensing Agency within (60) days of the effective date of change. (3-15-22)~~

074. Licensee Responsibility. The licensee of the facility is responsible for the operation of the residential assisted living facility~~, even when a separate administrator is employed~~. ~~(3-15-22)~~( )

101. --~~104.~~ ~~(RESERVED)~~

~~**105. CHANGE OF OWNERSHIP.**~~

~~**01. Non-Transfer of Facility License**. A facility license is not transferable from one (1) individual to another, from one (1) business entity to another, or from one (1) location to another. When a change of licensee, ownership, lease, or location occurs, the facility must be re-licensed. The new licensee must follow the application procedures, and obtain a license, before commencing operation as a facility. (3-15-22)~~

~~**02. Application for Change of Ownership**. The application for a change of ownership must be submitted to the Licensing Agency at least ninety (90) days prior to the proposed date of change. (3-15-22)~~

~~**03. Change of Ownership for a Facility in Litigation**. An application for change of ownership of a facility from a person who is in litigation for failure to meet licensure standards, or who has had a license revoked, must include evidence that there is a bona fide, arms length agreement and relationship between the two (2) parties. An entity purchasing a facility with an enforcement action acquires the enforcement action. (3-15-22)~~

~~**106. —** 109. (RESERVED)~~

110. FACILITY LICENSE APPLICATION.

01. License Application. License application forms are available online at the Licensing Agency's website at http://assistedliving.dhw.idaho.gov. The applicant must provide the following information: (3-15-22)

~~**a. A written statement that the applicant has thoroughly read and reviewed the statute, Title 39, Chapter 33, Idaho Code, and IDAPA 16.03.22, "Residential Assisted Living Facilities," and is prepared to comply with both; (3-15-22)~~

~~**b. A written statement and documentation that demonstrate no license revocation or other enforcement action is in the process of being taken, against a license held, or previously held, by the applicant in Idaho or any other state or jurisdiction; (7-1-24)~~

~~**c. When the applicant is a firm, association, organization, partnership, business trust, corporation, government entity, or company, the administrator and other members of the organization who directly influence the facility's operation must provide the information contained in this rule; (3-15-22)~~

~~**d. Each shareholder or investor holding twenty percent (20%) or more interest in the business must be listed on the application; (7-1-24)~~

~~**e**~~**a.** A copy of the Certificate of Assumed Business Name from the Idaho Secretary of State; (3-15-22)

~~**f. A statement from the local fire authority that the facility is located in a lawfully constituted fire district or affirmation that a lawfully constituted fire authority will respond to a fire at the facility; (3-15-22)~~

~~**g. A statement from a licensed electrician or the local or state electrical inspector that all wiring in the facility complies with current electrical codes; (3-15-22)~~

~~h. When the facility does not use an approved municipal water or sewage treatment system, a statement from a local environmental health specialist with the public health district indicating that the water supply and sewage disposal system meet the Department's requirements and standards;~~ (3-15-22)

~~i~~b. A complete set of printed operational policies and procedures; (3-15-22)

~~j. A detailed floor plan of the facility, including measurements of all rooms, or a copy of architectural drawings. See Sections 250 through 260, and Sections 400 through 430 of these rules.~~ (3-15-22)

~~k~~c. A copy of the Purchase Agreement, Lease Agreement, or Deed;~~ and~~ (3-15-22)( )

~~l. For facilities with nine (9) beds or more, signatures must be obtained from the following:~~ (3-15-22)

d. A detailed floor plan of the facility, including measurements of all rooms, or a copy of architectural drawings; and ( )

e. The following must be obtained: ( )

i. ~~The local zoning official documenting that the facility meets local zoning codes for occupancy~~Occupancy permit that the facility is located in a lawfully constituted fire district or affirmation that a lawfully constituted fire authority will respond to a fire at the facility; (3-15-22)( )

ii. ~~The local building official documenting that the facility meets local building codes for occupancy; and~~Occupancy permit that all wiring in the facility complies with current electrical codes; (3-15-22)( )

iii. ~~The~~Occupancy permit or evidence that the facility meets local zoning codes for occupancy and local fire official documenting that the facility meets local fire codes for occupancy. (3-15-22)( )

02. Written Request for Building Evaluation. The applicant~~ must request~~ submits a request in writing to the Licensing Agency for a building evaluation~~ of existing buildings. The request~~. It must include the physical address of the building~~ that is to be evaluated and~~, the name,~~ address, and~~ telephone number of the person who is to receive the building evaluation report, and be accompanied by a five hundred dollar ($500) initial building evaluation fee. (3-15-22)( )

~~**03. Building Evaluation Fee**. This application and request must be accompanied by a five hundred dollar ($500) initial building evaluation fee.~~ (3-15-22)

0~~4~~3. **Identification of the Licensed Administrator**. The applicant must provide a copy of the administrator's license and criminal history background check~~, and the current address for the primary residence of the administrator~~. (3-15-22)( )

~~**05. Failure to Complete Application Process**. Failure of the applicant to complete the Licensing Agency's application process within six (6) months of the original date of application, may result in a denial of the application. If the application is denied, the applicant is required to initiate a new licensing application process.~~ (3-15-22)

111. -- 114. (RESERVED)

115. EXPIRATION AND RENEWAL OF LICENSE.

01. Application for License Renewal. The facility must submit to the Licensing Agency an annual report and application for renewal of a license at least thirty (30) days prior to the expiration of the existing license. (3-15-22)

02. Existing License. The existing license, unless suspended, surrendered, or revoked, remains in force

and effect until the Licensing Agency has acted upon the application renewal, when such application for renewal has been filed. (3-15-22)

116. -- 125. (RESERVED)

126. EFFECT OF ENFORCEMENT ACTION AGAINST A LICENSE.
The Department will not review an application of an applicant who has an action, either current or in process, against a license held by the applicant ~~either~~ in Idaho ~~or any other state or jurisdiction~~. ~~(3-15-22)~~( )

127. FREQUENCY OF INSPECTIONS.

01. No Core Issues. Facilities without core issue deficiencies during two (2) consecutive licensure surveys, will be inspected at least every thirty-six (36) months. For facilities with core issue deficiencies, surveys will be conducted at the discretion of the Licensing Agency, at least every fifteen (15) months. ( )

02. Complaint Investigations. Complaint investigations will occur based on the severity of the complaint. ( )

03. Correction of Non-Core Issues. The facility must correct non-core issues within thirty (30) calendar days of the exit conference. If the facility is unable to meet this timeframe, they must inform the Department within thirty (30) calendar days of the exit conference. ( )

12~~7~~8. – 14~~9~~50. (RESERVED)

~~**150. POLICIES AND PROCEDURES.**~~
~~The facility must develop a written, dated set of policies and procedures that are specific to the population served in the facility and are available to all staff at all times to direct and ensure compliance with these rules. Policy topics must include abuse, neglect, exploitation, incidents and accidents, activities, admissions, emergency preparedness, infection control, nursing, resident rights, staffing, and medications.~~ ~~(3-15-22)~~

151. ACTIVITY REQUIREMENTS.

Each facility must develop and implement a written activity policy that ~~assists,~~ encourages, and promotes residents to ~~maintain and develop their highest potential for independent living through their participation~~ participate in planned, recreational, and other activities. ~~The facility must provide opportunities for the following:~~ ~~(3-15-22)~~( )

~~**01. Socialization**. Socialization through group discussion, conversation, recreation, visiting, arts and crafts, and music;~~ ~~(3-15-22)~~

~~**02. Physical Activities**. Physical activities such as games, sports, and exercises which develop and maintain strength, coordination, and range of motion;~~ ~~(3-15-22)~~

~~**03. Education**. Education through special classes or events; and~~ ~~(3-15-22)~~

~~**04. Community Resources for Activities**. The facility will utilize community resources to promote resident participation in integrated activities of their choice both in and away from the facility.~~ ~~(3-15-22)~~

152. ADMISSION REQUIREMENTS.

01. Admissions Policies. Each facility must develop and implement written admission policies and procedures, which must include: (3-15-22)

a. The purpose, quantity, and characteristics of available services; (3-15-22)

~~**b.** Limitations concerning delivery of routine personal care by persons of the opposite gender;~~ ~~(3-15-22)~~

~~c. Notification to potential and existing residents and responsible parties if the facility accepts any residents who are on the sexual offender registry. The registry may be accessed online at http://isp.idaho.gov/sor_id/search.html; and~~ (3-15-22)

~~d. Notification to potential and existing residents if non-resident adults or children reside in the facility.~~ (3-15-22)

~~02~~b. ~~Resident Admission, Discharge, and Transfer.~~ ~~The facility must have policies~~Criteria for addressing admission, discharge, and transfer of residents to, from, or within the facility. ~~(3-15-22)~~( )

0~~3~~2. ~~Policies of~~ Acceptable Admissions. ~~Written descriptions of the conditions~~ Policies for admitting residents to the facility must include: ~~(3-15-22)~~( )

~~a. A resident will be admitted or retained only when:~~ ~~(3-15-22)~~

~~i~~a. The facility has the capability, capacity, and services to provide appropriate care; (3-15-22)

~~ii~~b. The resident does not require a type of service for which the facility is not licensed to provide or which the facility does not provide or arrange for; and (3-15-22)

~~iii~~c. The facility has the personnel, appropriate in numbers and with appropriate knowledge and skills to provide such services. (3-15-22)

153. FINANCIAL REQUIREMENTS.
Each facility must develop and implement financial policies and procedures that include: (3-15-22)

01. ~~Statement~~Resident Funds. A ~~statement~~ policy specifying ~~if~~ how the facility ~~does not~~ will manage resident funds. ~~(3-15-22)~~( )

02. Safeguarding of Funds. ~~Policies should s~~ Specify how residents' funds will be ~~handled~~ managed and safeguarded~~,~~ and be in compliance with Section 39-3316, Idaho Code. ~~I~~If the facility does manage resident funds~~.~~ ~~P~~policies must address the following: ~~(3-15-22)~~( )

~~a. When a resident's funds are deposited with, or handled by the facility, the funds must be managed as described in Section 39-3316, Idaho Code, and Section 550 of these rules;~~ ~~(3-15-22)~~

~~b. A description of how facility fees are handled;~~ ~~(3-15-22)~~

~~c. Resident accounts and funds must be separate from any facility accounts;~~ ~~(3-15-22)~~

~~d~~a. The facility cannot require a resident to purchase goods or services from the facility, other than items specified in the admission agreement and facility policies; (3-15-22)

~~e~~b. Each transaction ~~with resident funds~~ must ~~be documented at the time to include signatures of the resident and facility representative with copies of receipts;~~ include copies of receipts. ~~(3-15-22)~~( )

~~f. Residents must have access to their personal funds during normal business hours; and~~ ~~(3-15-22)~~

~~g~~03. Funds at Discharge. When a resident permanently leaves the facility, the facility can only retain room and board funds prorated to the last day of the thirty (30) day notice~~, except in situations described in Sections 217 and 550 of these rules~~. Per the admissions agreement, the facility may charge a fee for the repair of damages or cleaning the room. All remaining funds are the property of the resident. ~~(3-15-22)~~( )

154. ~~STAFF TRAINING~~ RESIDENT SAFETY REQUIREMENTS.
The facility must develop ~~and implement~~ a written, dated set of policies and procedures that are specific to the populations served in the facility and are available to all staff at all times to direct and ensure compliance with these rules. The facility must develop and implement policies and procedures to address the following: ~~(3-15-22)~~( )

01. Response ~~of Staff~~ to Accidents, Incidents, or Allegations of Abuse, Neglect, or Exploitation of Residents. ~~The facility must develop policies and procedures to ensure that~~ This includes how accidents, incidents, or allegations of abuse, neglect, and exploitation are identified, documented, reported, investigated, and followed-up with interventions to prevent re-occurrence and ensure protection. ~~(3-15-22)~~( )

02. Response ~~of Staff~~ to Emergencies. ~~How staff are to respond to~~ Staff responsibilities in emergency situations, including: ~~(3-15-22)~~( )

a. Medical and psychiatric emergencies; (3-15-22)

b. Resident absence; (3-15-22)

c. Criminal situations; and (3-15-22)

d. Presence of law enforcement officials at the facility. (3-15-22)

03. Notification of Changes to Resident Health or Mental Status. ~~Who and how staff are to notify of~~ Staff responsibilities and notification requirements for any changes in residents' health or mental status. ~~(3-15-22)~~( )

04. Provided Care and Services by Staff. ~~How s~~ Staff ~~are to provide~~ responsibilities when providing care and services to residents in the following areas: ~~(3-15-22)~~( )

a. Activities of daily living; (3-15-22)

b. Dietary and eating, including when a resident refuses to eat or follow a prescribed diet; (3-15-22)

c. Dignity; (3-15-22)

d. Ensuring each individual's rights; (3-15-22)

e. Medication assistance; (3-15-22)

f. Provision of privacy; (3-15-22)

g. Social activities; (3-15-22)

h. Supervision; (3-15-22)

i. Supporting resident independence; and (3-15-22)

j. Telephone access. (3-15-22)

~~**05. Intervention Procedures to Ensure Safety of Residents and Staff**. How to intervene to ensure resident and staff safety in unsafe situations that are physically or behaviorally caused.~~ ~~(3-15-22)~~

0~~6~~5. Behavior Management for Residents. The facility must have policies and procedures to ensure staff are trained and complete timely assessment, plan development, and documentation as described in Section 330 of these rules. (3-15-22)

0~~7~~6. Facility Operations, Inspections, Maintenance, and Testing. Plans and procedures for the operation, periodic inspection, and testing of the physical plant, which includes utilities, fire safety, and plant maintenance for all areas of the facility's campus. (3-15-22)

0~~8~~7. Hazardous Materials. The handling of hazardous materials. (3-15-22)

0~~9~~8. **Mechanical Equipment**. The handling of potentially dangerous mechanical equipment. (3-15-22)

09. **Smoking Requirements**. The facility must develop and implement written rules governing smoking. Smoking policies must be available to staff, residents, and visiting public and must ensure: ( )

a. Smoking is prohibited in areas where combustible supplies or materials, flammable liquids, gases, or oxidizers are in use or stored. ( )

b. Smoking in bed is prohibited. ( )

c. Unsupervised smoking by residents classified as not mentally or physically responsible, sedated by medication, or taking oxygen is prohibited. ( )

d. If smoking is permitted, there must be designated smoking areas which are clearly marked. Designated smoking areas must have non-combustible disposal receptacles. ( )

155. EMERGENCY PREPAREDNESS REQUIREMENTS.
Each facility must develop and implement an emergency preparedness plan ~~to follow~~ in the event of fire, explosion, ~~flood, earthquake, high wind~~ natural disaster, or other emergency. ~~(3-15-22)~~( )

01. **Relocation Agreements**. Each facility must have a current written agreement developed between the facility and two (2) separate locations to which residents would be relocated in the event the building is evacuated and cannot be reoccupied. ~~The facility will review the relocation agreements annually.~~ ~~(3-15-22)~~( )

02. **Written Procedures**. The facility must have written procedures outlining steps to be taken in the event of an emergency including: (3-15-22)

a. Each person's responsibilities; (3-15-22)

b. Where and how residents are to be evacuated; and (3-15-22)

c. Notification of emergency agencies. (3-15-22)

~~**03. Emergency Generators**. Facilities that elect to have an emergency generator must ensure that the system is designed to meet the applicable codes in NFPA, Standard 110 (within NFPA, Standard 101 as incorporated in Section 004 of these rules).~~ ~~(3-15-22)~~

156. HOURLY ADULT CARE REQUIREMENTS.
Facilities offering hourly adult care must develop and implement written policies and procedures which include the following: (3-15-22)

01. **Services Offered**. A description of hourly adult care services, including transportation services (if offered), meals, medical assistance, activities, ~~and~~ supervision, and documentation requirements. ~~(3-15-22)~~( )

~~**02. Individuals Accepted**. Types of individuals who may or may not be accepted for hourly adult care. See Section 152 of these rules.~~ ~~(3-15-22)~~

~~**03. Cost of Hourly Adult Care**. Details of the cost of hourly adult care for the person receiving services.~~ ~~(3-15-22)~~

~~**04. Hours for Care**. The specific time periods of hourly adult care, not to exceed fourteen (14) consecutive hours in a twenty-four (24) hour period.~~ ~~(3-15-22)~~

~~**05. Assistance with Medications**. Assistance with medications in the facility must comply with IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," including:~~ ~~(3-15-22)~~

~~**a.** Copies of all physician or authorized provider orders, including orders for all prescribed~~

~~medications and treatments.~~ ~~(3-15-22)~~

~~**b.** Appropriately labeled medications and treatments the facility safeguards while the person receives hourly adult care.~~ ~~(3-15-22)~~

02. **Hourly Adult Care**. The facility must keep record of names, dates, and description of services provided. ( )

0~~6~~3. **Staffing**. Staffing must be based on the needs of the entire facility, including those receiving hourly adult care and residents. Hourly adult care may be provided to as many individuals as possible without disrupting the day-to-day operations and normal activities of the facility. (3-15-22)

0~~7~~4. **Accommodations**. The facility must provide accommodations appropriate to the time frame for those receiving hourly adult care~~, including:~~. ~~(3-15-22)~~( )

~~**a.** Daytime accommodations such as recliners and couches for napping. Napping furniture must be spaced at least (3) feet apart.~~ ~~(3-15-22)~~

~~**b.** Evening accommodations such as beds and bedrooms that are not used by facility residents. Any bed used overnight by a person receiving hourly adult care will not be counted as a licensed bed.~~ ~~(3-15-22)~~

~~**08.** **Documentation**. Documentation requirements described in Section 330 of these rules.~~ ~~(3-15-22)~~

157. --~~160.~~ **~~(RESERVED)~~**

~~161. SMOKING REQUIREMENTS.~~

~~The facility must develop and implement written rules governing smoking. Nothing in this rule requires a facility to permit smoking. Smoking policies must be made known to all staff, residents, and visiting public and must ensure:~~ ~~(3-15-22)~~

~~**01.** **Combustible Supplies and Flammable Items**. Smoking is prohibited in areas where combustible supplies or materials, flammable liquids, gases, or oxidizers are in use or stored.~~ ~~(3-15-22)~~

~~**02.** **Smoking in Bed**. Smoking in bed is prohibited.~~ ~~(3-15-22)~~

~~**03.** **Unsupervised Smoking**. Unsupervised smoking by residents classified as not mentally or physically responsible, sedated by medication, or taking oxygen is prohibited.~~ ~~(3-15-22)~~

~~**04.** **Designated Smoking Areas**. If smoking is permitted, there must be designated smoking areas which are specified in policy and clearly marked. Designated smoking areas must have non-combustible disposal receptacles.~~ ~~(3-15-22)~~

~~162.~~ 215. (RESERVED)

216. REQUIREMENTS FOR RESIDENT ADMISSION~~AGREEMENT~~S.

~~**01.** **Initial Resident Assessment and Care Plan**. Prior to admission, each resident must be assessed by the facility to ensure the resident is appropriate for placement in their residential assisted living facility. The facility must develop an interim care plan to guide services until the facility can complete the resident assessment process. The result of the assessment will determine the need for specific services and supports.~~ ~~(3-15-22)~~

01. **Pre-Admission**. Prior to admission, each resident must be assessed by the facility to ensure the resident is appropriate for placement in their residential assisted living facility. The assessment must include the following: ( )

a. Documentation of level of assistance required for activities of daily living including bathing,

dressing, toileting, grooming, eating, communicating and the use of adaptive equipment; ( )

b. Pre-admission nursing assessment; ( )

c. Documentation of any maladaptive behaviors including history, intensity, duration, and frequency, including potential contributing factors and mitigation efforts; and ( )

d. Documentation of the need for related outside services, including service type, name and frequency. ( )

02. Written Agreement. Prior to, or on the day of admission, the facility and each resident or the resident's legal guardian or conservator must enter into a written admission agreement ~~that is transparent, understandable, and is translated into a language the resident or their representative understands. The admission agreement will provide a complete reflection of the facility's charges, commitments agreed to by each party, and the actual practices that will occur in the facility. The agreement must be signed by all involved parties, and a complete copy provided to the resident and the resident's legal guardian or conservator prior to, or on the day of admission. The admission agreement may be integrated within the Negotiated Service Agreement (NSA), provided that all requirements for the NSA in Section 320 of these rules and the admission agreement are met. Admission agreements must include all items described under this rule~~. The admission agreement will provide a complete reflection of the facility's charges, commitments agreed to by each party, and the services to be provided by the facility. The agreement must include the following: ~~(3-15-22)~~( )

~~**03. Services, Supports, and Rates**. The facility must identify the following services, supports, and applicable rates: (3-15-22)~~

~~**a.** Unless otherwise negotiated with the resident or the resident's legal guardian or conservator, basic services must include the items specified in Section 430 of these rules. (3-15-22)~~

~~**b.** The resident's monthly charges, including a specific description of the services that are included in the basic services rate and the charged rate. (3-15-22)~~

~~**c.** All prices, formulas, and calculations used to determine the resident's basic services rate including: (3-15-22)~~

~~i. Service packages; (3-15-22)~~

~~ii. Fee-for-service rates; (3-15-22)~~

~~iii. Assessment forms; (3-15-22)~~

~~iv. Price per assessment point; (3-15-22)~~

~~v. Charges for levels of care determined with an assessment; and (3-15-22)~~

~~vi. Move-in fees or other similar charges. (3-15-22)~~

~~**d.** The services and rates charged for additional or optional services, supplies, or amenities that are available through the facility or arranged for by the facility for which the resident will be charged additional fees. (3-15-22)~~

~~**e.** Services or rates that are impacted by an updated assessment of the resident, the assessment tool, the assessor, and the frequency of the assessment, when the facility uses this assessment to determine rate changes. (3-15-22)~~

~~**f.** The facility may charge residents for the use of personal furnishings, equipment, and supplies provided by the facility unless paid for by a publicly funded program. The facility must provide a detailed itemization of furnishings, equipment, supplies, and the rate for those items the resident will be charged. (3-15-22)~~

~~04~~a. ~~Staffing. The agreement must i~~Identify staffing patterns and qualifications of staff on duty during a normal day. ~~(3-15-22)~~( )

~~05. Notification of Liability Insurance Coverage. The administrator of a residential assisted living facility must disclose in writing at the time of admission or before a resident's admission if the facility does not carry professional liability insurance. If the facility cancels the professional liability insurance all residents must be notified of the change in writing. (3-15-22)~~

~~06~~b. ~~Medication Responsibilities. The agreement must i~~Identify the facility's and resident's roles and responsibilities relating to assistance with medications including the reporting of missed medications or those taken on a PRN basis. ~~(3-15-22)~~( )

~~07~~c. ~~Resident Personal Fund Responsibilities. The agreement must i~~Identify who is responsible for the resident's personal funds. ~~(3-15-22)~~( )

~~08~~d. ~~Resident Belongings Responsibility. The agreement must i~~Identify responsibility for protection and disposition of all valuables belonging to the resident and provision for the return of the resident's valuables if the resident leaves the facility. ~~(3-15-22)~~( )

~~09~~e. ~~Emergency Transfers. The agreement must i~~Identify conditions under which emergency transfers will be made as provided in Section 152 of these rules. ~~(3-15-22)~~( )

~~10~~f. ~~Billing Practices, Notices, and Procedures for Payments and Refunds. The facility must p~~Provide a description of the facility's billing practices, notices, and procedures for payments and refunds. The following procedures must be included: ~~(3-15-22)~~( )

~~a~~i. Arrangement for payments; (3-15-22)

~~b~~ii. Under what circumstances and time frame a partial month's resident fees are to be refunded when a resident no longer resides in the facility; and (3-15-22)

~~c~~iii. Written notice to vacate the facility must be given thirty (30) calendar days prior to transfer or discharge on the part of either party, except in the case of the resident's emergency discharge or death. The facility may charge up to fifteen (15) days prorated rent from the date of the resident's emergency discharge or death. The agreement must disclose any charges that will result when a resident fails to provide a thirty (30) day written notice. (3-15-22)

~~11~~g. ~~Resident Permission to Transfer Information. The agreement must s~~Specify permission for the facility to transfer information from the resident's records to any facility to which the resident transfers. ~~(3-15-22)~~( )

~~12~~h. ~~Resident Responsibilities. The agreement must s~~Specify resident responsibilities. ~~(3-15-22)~~( )

~~13~~i. ~~Restrictions on Choice of Care or Service Providers. The agreement must s~~Specify any restriction on choice of care or service providers, such as home health agency, hospice agency, or personal care services. ~~(3-15-22)~~( )

~~14~~j. ~~Advance Directive. The agreement must i~~Identify written documentation of the resident's preference regarding the formulation of an advance directive in accordance with Idaho state law. When a resident has an advance directive, a copy must be immediately available for staff and emergency personnel. ~~(3-15-22)~~( )

~~15. Notification of Payee Requirements. The agreement must identify if the facility requires as a condition of admission that the facility be named as payee. (3-15-22)~~

~~16~~k. ~~Contested Charges. The facility must p~~Provide the methods by which a resident may contest charges or rate increases including contacting the ombudsman for the elderly. ~~(3-15-22)~~( )

~~17~~l. ~~**Transition to Publicly Funded Program**. The facility must d~~Disclose the conditions under which the resident can remain in the facility if payment for the resident shifts to a publicly funded program. ~~(3-15-22)~~( )

~~18~~m. ~~**Smoking Policy**. The admission agreement must i~~Include a copy of the facility's smoking policy. ~~(3-15-22)~~( )

217. REQUIREMENTS FOR TERMINATION OF ADMISSION AGREEMENT.

~~**01. Conditions for Termination of the Admission Agreement**. The admission agreement cannot be terminated, except under Section 39-3313, Idaho Code, as follows: (3-15-22)~~

~~**a.** Giving the other party thirty (30) calendar days written notice; (3-15-22)~~

~~**b.** The resident's death; (3-15-22)~~

~~**c.** Emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm; (3-15-22)~~

~~**d.** The resident's mental or medical condition deteriorates to a level requiring care as described in Section 39-3307, Idaho Code, and Section 152 of these rules; (3-15-22)~~

~~**e.** Nonpayment of the resident's fees; (3-15-22)~~

~~**f.** When the facility cannot meet resident needs due to changes in services, in house or contracted, or inability to provide the services; or (3-15-22)~~

~~**g.** Other written conditions as may be mutually established between the resident, the resident's legal guardian or conservator, and the administrator of the facility at the time of admission. (3-15-22)~~

01. Notification. Before a facility discharges a resident, the facility must notify the resident or their representative in writing and their representative of the discharge and the cause. ( )

02. Facility Responsibility During Resident Discharge. The facility is responsible to assist the resident with transfer by providing a list of skilled nursing facilities, other residential assisted living facilities, and certified family homes that may meet the needs of the resident. ~~The facility must provide a copy of the resident record, as described in Section 330 of these rules, within two (2) business days of receipt of a request signed and authorized by the resident or legal representative. (3-15-22)~~( )

~~**03. Resident's Appeal of Involuntary Discharge**. A resident may appeal all discharges, with the exception of an involuntary discharge in the case of nonpayment or emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm. (3-15-22)~~

~~**a.** Before a facility discharges a resident, the facility must notify the resident and their representative of the discharge and the cause. (3-15-22)~~

~~**b.** This notice must be in writing and in a language and manner the resident or their representative can understand. (3-15-22)~~

0~~4~~3. **Written Notice of Discharge**. The written notice of discharge must include the following: (3-15-22)

a. The specific reason for the discharge; (3-15-22)

b. The effective date of the discharge; (3-15-22)

~~c.~~ ~~A statement that the resident has the right to appeal the discharge to the Department within thirty (30) calendar days of receipt of written notice of discharge;~~ ~~(3-15-22)~~

~~d~~c. ~~The Residential Assisted Living Facilities Program website, where the appeal must be submitted~~A statement informing the resident of their appeal rights including timelines and methods; ~~(3-15-22)~~( )

~~e~~d. The name, address, and telephone number of the local ombudsman; (3-15-22)

~~f~~e. The name, address, and telephone number of Disability Rights Idaho; (3-15-22)

~~g~~f. If the resident fails to pay fees to the facility~~, as agreed to in the admission agreement,~~ during the discharge appeal process, the resident's appeal of the involuntary discharge becomes null and void and the discharge notice applies; and ~~(3-15-22)~~( )

~~h~~g. When the notice does not contain all the above required information, the notice is void and must be reissued. (3-15-22)

04. Resident's Appeal of Involuntary Discharge. A resident may appeal all discharges, with the exception of an involuntary discharge in the case of nonpayment or emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm. ( )

05. Receipt of Appeal. ~~Request for an appeal must be received by t~~The Department must receive the appeal request within thirty (30) calendar days of ~~the resident's or resident's representative's receipt of written notice of discharge to stop the discharge before it occurs~~ receipt of written notice of discharge. ~~(3-15-22)~~( )

218. -- 249. (RESERVED)

250. REQUIREMENTS FOR BUILDING CONSTRUCTION AND PHYSICAL STANDARDS.
~~Minimum construction must meet all requirements of this rule to include codes and standards incorporated by reference in Section 004 of these rules, and all local and state codes that are applicable to residential assisted living facilities. Where there are conflicts between the requirements in the codes, the most restrictive condition must apply.~~ ~~(3-15-22)~~

01. Construction Changes. For all new construction, changes of occupancy, modifications, additions, or renovations to existing buildings, the facility must submit construction drawings with specifications to the licensing authority for review and approval prior to any work being started. All new construction and conversions must install audible and visual notification devices for fire alarm systems in all common areas and resident rooms no matter the size of facility. (3-15-22)

02. Plans and Specifications. Plans must be prepared, signed, stamped, and dated by an architect or engineer licensed in the state of Idaho~~. A variance of this requirement may be granted by the Licensing Agency when the size of the project does not necessitate involvement of an architect or engineer. This must include the following:~~ and submitted to the Department after approval of local authorities. ~~(3-15-22)~~( )

~~a. Plans and specifications must be submitted to the Licensing Agency to ensure compliance with applicable construction standards, codes, and regulations;~~ ~~(3-15-22)~~

~~b. Plans must be drawn to scale, but no less than a scale of one-eighth (1/8) inch to one (1) foot;~~ ~~(3-15-22)~~

~~c. Plans must be submitted electronically;~~ ~~(3-15-22)~~

~~d. A physical address approved by the city;~~ ~~(3-15-22)~~

~~e. Life safety plans;~~ ~~(3-15-22)~~

~~f. Fire alarm shop drawings; and~~ ~~(3-15-22)~~

~~g. Fire sprinkler system drawings and calculations.~~ (3-15-22)

03. Approval. All buildings, additions, and renovations are subject to approval by the Licensing Agency and must meet applicable requirements. (3-15-22)

~~**04. Walls and Floor Surfaces**. Walls and floors must be of such character to permit cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have washable surfaces.~~ (3-15-22)

054. Toilets and Bathrooms. Each facility must provide: (3-15-22)

a. A toilet and bathroom for resident use so arranged that it is not necessary for an individual to pass through another resident's room to reach the toilet or bath; (3-15-22)

b. Solid walls or partitions to separate each toilet and bathroom from all adjoining rooms; (3-15-22)

c. Mechanical ventilation to the outside from all inside toilets and bathrooms not provided with an operable exterior window; (3-15-22)

d. ~~Each tub, shower, and lavatory with hot and cold running water~~Adequate number of bathrooms to meet the needs of the residents admitted to the facility; ~~(3-15-22)~~( )

~~**e.** At least one (1) flushing toilet for every six (6) residents;~~ (3-15-22)

~~**f.** At least one (1) tub or shower for every eight (8) residents;~~ (3-15-22)

~~**g.** At least one (1) lavatory with a mirror for each toilet; and~~ (3-15-22)

~~**h.** At least one (1) toilet, tub or shower, and lavatory in each building in which residents sleep, with additional units if required by the number of persons.~~ (3-15-22)

065. Accessibility for Persons with Mobility and Sensory Impairments. For residents who have mobility or sensory impairments, the facility must provide a physical environment which meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. New construction must meet the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities must comply, to the maximum extent feasible~~, with 28 CFR Sections 36.304 and 36.305 regarding removal of barriers under the Americans with Disabilities Act, without creating an undue hardship or burden on the facility, and must provide as required, the necessary accommodations:~~. ~~(3-15-22)~~( )

~~**a.** Ramps for residents who require assistance with ambulation must comply with the requirements of the ADAAG 4.8;~~ (3-15-22)

~~**b.** Bathrooms and doors large enough to allow the easy passage of a wheelchair as provided for in the ADAAG 4.13;~~ (3-15-22)

~~**c.** Grab bars in resident toilet and bathrooms in compliance with ADAAG 4.26;~~ (3-15-22)

~~**d.** Toilet facilities in compliance with ADAAG 4.16 and 4.23;~~ (3-15-22)

~~**e.** Non-retractable faucet handles in compliance with ADAAG 4.19, with the exception of self-closing valves under 4.19.5, and 4.27; and~~ (3-15-22)

~~**f.** A suitable hand railing must be provided on both sides of all stairs leading into and out of a building for residents who require the use of crutches, walkers, or braces.~~ (3-15-22)

~~**07. Lighting**. The facility must provide adequate lighting in all resident sleeping rooms, dining rooms, living rooms, recreation rooms, and hallways.~~ (3-15-22)

~~08.~~ ~~**Ventilation**. The facility must be ventilated, and precautions taken to prevent offensive odors.~~ ~~(3-15-22)~~

0~~9~~6. **Plumbing**. ~~All plumbing in the facility must comply with local and state codes. All plumbing fixtures must be easily cleanable and maintained in good repair.~~ The temperature of hot water at plumbing fixtures used by residents must be between one hundred five degrees Fahrenheit (105°F) and one hundred twenty degrees Fahrenheit (120°F). ~~(3-15-22)~~( )

~~10~~07. **Heating, Ventilation, and Air-Conditioning (HVAC)**. Equipment must be furnished, installed, and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes. An HVAC system must be ~~provided for the facility that is~~ capable of maintaining a minimum temperature of seventy degrees Fahrenheit (70°F) and a maximum temperature of seventy-eight degrees Fahrenheit (78°F) during the day, and a minimum of sixty-two degrees Fahrenheit (62°F) and a maximum temperature of seventy-five degrees Fahrenheit (75°F) during the night. Wood stoves, gas fireplaces, or solid burning fireplaces are not permitted as the sole source of heat, and the thermostat for the primary source of heat must be remotely located away from any of these sources. ~~(3-15-22)~~( )

a. Portable heating devices of any kind are prohibited~~. Portable electric space heaters and movable fuel-fired heaters are considered portable comfort heating devices. Exceptions are heated mattress pads, electric blankets, and heating pads when ordered by an authorized provider or physician~~ in resident sleeping areas; ~~(3-15-22)~~( )

b. All fireplaces must provide a safety barrier~~ and have heat-tempered glass fireplace enclosures equivalent to ASTM Standard~~ that is tip resistant and ensures resident safety; ~~(3-15-22)~~( )

c. Boilers, hot water heaters, and unfired pressure vessels must be equipped with automatic pressure relief valves; (3-15-22)

d. Fire and smoke dampers must be inspected, serviced, and cleaned once every four (4) years by a person professionally engaged in the business of servicing these devices or systems. A copy of these results must be kept in the facility. (3-15-22)

~~11~~08. **Dining, Recreation, Shower, Bathing, and Living Space**. The total area set aside for these purposes must be no less than thirty (30) square feet per licensed bed. A hall or entry cannot be included as living or recreation space. (3-15-22)

~~12~~09. **Resident Sleeping Rooms**. The facility must ensure that: (3-15-22)

~~**a.** Resident sleeping rooms are not in attics, stairs, halls, or any other room commonly used for other than bedroom purposes; (3-15-22)~~

~~**b.** A room with a window that opens into an exterior window well cannot be used for a resident sleeping room; (3-15-22)~~

~~**c**~~**a.** Not more than ~~four~~ two (~~4~~2) residents can be housed in any multi-bed sleeping room ~~in facilities licensed prior to July 1, 1991. New facilities or buildings converted to a licensed facility after July 1, 1991, cannot have more than two (2) residents in any multi-bed sleeping room. When there is any change in ownership of the facility, the maximum number of residents allowed in any room is two (2)~~; ~~(3-15-22)~~( )

~~**d**~~**b.** Square footage requirements for resident sleeping rooms must provide for not less than one hundred (100) square feet of floor space per resident in a single-bed sleeping room and not less than eighty (80) square feet of floor space per resident in a multi-bed sleeping room. For facilities constructed after January 1, 2021, square footage requirements for resident sleeping rooms must provide at least one hundred (100) square feet of floor space per resident for both single-bed and multi-bed sleeping rooms. (3-15-22)

~~**e.** Each resident's sleeping room must be provided with an operable exterior window. An operable~~

~~window is not required where there is a door directly to the outside from the sleeping room;~~ ~~(3-15-22)~~

~~**f.** The operable window sill height must not exceed thirty-six (36) inches above the floor in new construction, additions, or remodeling;~~ ~~(3-15-22)~~

~~**g**~~**c.** The operable window sill height must not exceed forty-four (44) inches above the floor in existing buildings being ~~converted to a facility~~; ~~(3-15-22)~~( )

~~**h.** Each resident sleeping room must provide a total window space that equals at least eight percent (8%) of the room's total square footage;~~ ~~(3-15-22)~~

~~**i**~~**d.** Window screens must be provided on operable windows; and ~~(3-15-22)~~( )

~~**j.** Resident sleeping rooms must have walls that run from floor to ceiling, have doors that will limit the passage of smoke, and provide the resident(s) with privacy;~~ ~~(3-15-22)~~

~~**k.** Ceiling heights in sleeping rooms must be at least seven (7) feet, six (6) inches; and~~ ~~(3-15-22)~~

~~**l**~~**e.** Closet space in each resident sleeping room must provide at least four (4) usable square feet per resident. Common closets used by two (2) or more residents must have substantial dividers for separation of each resident's clothing. All closets must be equipped with doors. Free-standing closets are deducted from the square footage of the sleeping room. (3-15-22)

1~~3~~0. **Secure Environment**. If the facility accepts and retains residents who have cognitive impairment and have a history of elopement or attempted elopement, the facility must provide an interior environment and exterior yard that is secure and safe. ~~Because measures to secure the environment may be effective for one (1) resident, but not another, the type of the security provided must be evaluated for effectiveness in protecting each resident, based on their individual needs and abilities, and adjusted as necessary. These measures must be incorporated into the NSA of each applicable resident~~ The secured environment and security provided must be evaluated and adjusted as necessary to meet the needs of all residents. ~~(3-15-22)~~( )

141. **Call System**. The facility must have a call system available for each resident ~~to call for assistance~~ and ~~still be ensured a~~ maintain the resident's right to privacy ~~at the facility~~, including in the resident's living quarters and common areas, during medical treatment, and other services, and in written and telephonic communications, or in visits with family, friends, advocates, and resident groups. The call system cannot be a substitute for supervision. ~~For facilities licensed prior to January 1, 2006, when the current system is no longer operational or repairable the facility must install a call system as defined in Section 010 of these rules.~~ ~~(3-15-22)~~( )

~~**15. Dietary Standards**. Each facility must have a full-service kitchen to meet the needs of the residents. Any satellite kitchen must meet all applicable requirements.~~ ~~(3-15-22)~~

251. -- ~~**254.**~~ ~~**(RESERVED)**~~

~~**255. REQUIREMENTS FOR ADDITIONAL PHYSICAL STANDARDS.**~~

~~**01. Fire District**. The facility site must be in a lawfully constituted fire district.~~ ~~(3-15-22)~~

~~**02. Roads**. The facility must be served by an all-weather road and kept open to motor vehicles at all times of the year.~~ ~~(3-15-22)~~

~~**03. Medical Accessibility**. The facility site must be accessible to authorized providers or emergency medical services within thirty (30) minutes driving time.~~ ~~(3-15-22)~~

~~**256. –**~~ **259. (RESERVED)**

260. REQUIREMENTS FOR ENVIRONMENTAL SANITATION.

01. Water Supply. ~~The facility must have an adequate water supply that is safe and of a sanitary quality~~ Water supply must be from an approved private, public, or municipal water supply. ~~(3-15-22)~~( )

~~**a.** The water supply must be from an approved private, public, or municipal water supply; (3-15-22)~~

~~**b**~~**a.** Water from a private supply must have water samples submitted annually to either a private accredited laboratory or to the Public Health District Laboratory for bacteriological examination. The Department may require more frequent examinations if warranted~~; and~~. ~~(3-15-22)~~( )

~~**c.** There must be a sufficient amount of water under adequate pressure to meet sanitary and fire sprinkler system requirements of the facility at all times. (3-15-22)~~

~~**02. Sewage Disposal.** All sewage and liquid waste must be discharged into a municipal sewage system where such a system is available. If a municipal sewage system is not available, sewage and liquid waste must be collected, treated, and disposed of in a manner approved by the Department. (3-15-22)~~

0~~3~~2. Garbage and Refuse Disposal. Garbage and refuse disposal must be provided to ensure that: (3-15-22)

a. The premises and all buildings must be kept free from the accumulation of weeds, trash, and rubbish; (3-15-22)

b. Material not directly related to the maintenance and operation of the facility must not be stored on the premises; and ~~(3-15-22)~~( )

~~**c.** All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material, and must not leak. Containers must be provided with tight-fitting lids unless stored in a vermin-proof room or enclosure; and (3-15-22)~~

~~**d**~~**c.** Garbage containers must be maintained in a sanitary manner. Sufficient containers must be afforded to hold all garbage and refuse which accumulates between periods of removal from the facility. ~~Storage areas must be clean and sanitary.~~ ~~(3-15-22)~~( )

0~~4~~3. Insect and Rodent Control. A pest control program must ~~be in effect at all times. This program must~~ effectively prevent insects, rodents, and other pests from entrance to, or infestation of, the facility. ~~(3-15-22)~~( )

0~~5~~4. Linen and Laundry Facilities and Services. (3-15-22)

a. The facility must have ~~available at all times a quantity of~~ linen ~~essential~~ suitable to the proper care and comfort of residents; and ~~(3-15-22)~~( )

b. ~~Linen must be of good quality, n~~Not thread-bare, torn, or stained; ~~(3-15-22)~~( )

c. ~~Linens must be h~~Handled, processed, and stored in an appropriate manner that prevents contamination; ~~(3-15-22)~~( )

~~**d.** Adequate facilities must be provided for the proper and sanitary washing and drying of linen and other washable goods laundered in the facility; (3-15-22)~~

~~**e**~~**d.** ~~The laundry must be s~~Situated in an area separate and apart from where food is stored, prepared, or served; ~~(3-15-22)~~( )

~~**f.** The laundry area must be well-lighted, ventilated, adequate in size for the needs of the facility, maintained in a sanitary manner, and kept in good repair; (3-15-22)~~

~~**g**~~**e.** ~~Care must be taken to ensure s~~Soiled linen and clothing ~~are~~ must be properly handled to prevent

contamination. Clean linen and clothing received from a laundry service must be stored in a proper manner to prevent contamination; and (3-15-22)( )

~~h~~f. Residents' and personnel's personal laundry must be collected, transported, sorted, washed, and dried in a sanitary manner and cannot be washed with general linens (e.g., towels and sheets). (3-15-22)

0~~6~~5. **Housekeeping and Maintenance Services**. Housekeeping, maintenance personnel, and equipment must be provided to maintain the interior and exterior of the facility in a clean, safe, and orderly manner. Prior to occupancy of any sleeping room by a new resident, the room must be thoroughly cleaned including the bed, bedding, and furnishings. (3-15-22)

0~~7~~6. **Toxic Chemicals**. All toxic chemicals must be properly labeled. Toxic chemicals cannot be stored where food is stored, prepared, or served, where medications are stored, and where residents with cognitive impairment have access. (3-15-22)

261. – 304. (RESERVED)

305. REQUIREMENTS FOR THE LICENSED ~~REGISTERED~~ NURSING ASSESSMENT.
For each resident the licensed ~~registered~~ nurse must assess ~~and~~, document, ~~including~~ date and ~~signature~~ sign, the following: ~~(3-15-22)~~( )

~~**01. Resident Medications and Therapies**. Each resident's use of, and response to all medications, (including over the counter, and prescribed therapies), the monitoring of side effects, interactions, abuse, or other adverse effects, and ensuring the resident's physician or authorized provider is notified of any identified concerns with medications and therapies.~~ ~~(3-15-22)~~

~~**02. Current Medication Orders and Treatment Orders**. Each resident's medication and treatment orders are current and verified for the following:~~ ~~(3-15-22)~~

~~**a.** The medication listed on the medication distribution container, including over the counter medications, is consistent with physician or authorized provider orders;~~ ~~(3-15-22)~~

~~**b.** The physician or authorized provider orders related to therapeutic diets, treatments, and medications for each resident are followed; and~~ ~~(3-15-22)~~

~~**c.** A copy of the actual written, signed, and dated orders are present in each resident's care record.~~ ~~(3-15-22)~~

01. Pre-Admission Assessment. A review of the resident's health and medical status including identification of medical and care needs. ( )

02. Quarterly Nursing Assessments. The facility nurse must visit the facility at least once every ninety (90) days to conduct quarterly assessments. The assessments must include: ( )

a. Review of the residents' health and medical status, including any changes in medical or physical status; and ( )

b. Recommendations for changes needed to the NSA to meet the residents' needs. ( )

03. Change in Resident Health Status. ~~The health status of each resident by conducting a p~~ Physical assessment ~~and~~, identifying symptoms of illness, or ~~any~~ changes in mental or physical health status. ~~(3-15-22)~~( )

04. Recommendations. ~~Recommendations to~~ Notify the administrator regarding any ~~medication needs, other health needs requiring follow-up, or~~ medical changes ~~needed~~ requiring amendments to the NSA. ~~The nurse must notify~~ Notify the physician or authorized provider of ~~recommendations for medical care and services that are needed~~ medical changes. ~~(3-15-22)~~( )

~~05. Progress of Previous Recommendations. The progress of previous recommendations regarding any medication needs or other health needs that require follow-up.~~ (3-15-22)

06~~5~~. **Self-Administered Medication**. ~~Each resident participating in a self-administered medication program at the following times:~~ Residents must be assessed prior to self-administering medications and every ninety (90) days thereafter. (3-15-22)( )

~~a. Before the resident can self-administer medication to ensure resident safety; and~~ (3-15-22)

~~b. Every ninety (90) days to evaluate the continued validity of the assessment to ensure the resident is still capable to safely self-administer medication(s).~~ (3-15-22)

~~07. Resident and Facility Staff Education. Recommendations for any health care-related educational needs, for both the resident and facility staff, as the result of the nursing assessment or at the direction of the resident's health care provider.~~ (3-15-22)

306. -- 309. (RESERVED)

310. REQUIREMENTS FOR MEDICATIONS AND TREATMENTS.
Facility policies and procedures must specify how medications will be handled. (3-15-22)

01. Medication Distribution ~~System~~. ~~Each facility must use medi-sets or blister packs for prescription medications. The facility may use multi-dose medication distribution systems that are provided for resident's receiving medications from the Veterans Administration or Railroad benefits. The medication system must be filled by a pharmacist and appropriately labeled in accordance with pharmacy standards and physician or authorized provider instructions. The facility's licensed nurse may fill medi-sets, blister packs, or other Licensing Agency approved systems as described in Section 39-3326, Idaho Code~~ The facility must ensure. ~~(3-15-22)~~( )

a. All medications must be kept in a locked area such as a locked box or room; (3-15-22)

b. Poisons, toxic chemicals, and cleaning agents must not be stored with medications; (3-15-22)

c. Biologicals and other medications requiring cold storage must be maintained ~~at thirty-eight degrees Fahrenheit to forty-five degrees Fahrenheit (38°F-45°F),~~ per manufacturer's guidelines and the temperature monitored and documented ~~daily~~ weekly; ~~(3-15-22)~~( )

~~d. Assistance with medication must comply with the Board of Nursing requirements;~~ (3-15-22)

~~e~~d. Each prescription medication must be given to the resident directly from the medi-set, blister pack, or medication container; (3-15-22)

~~f~~e. Each resident must be observed taking the medication; and (3-15-22)

f. Medications and treatments must be provided per physician or authorized provider orders. ( )

~~g. Each prescribed PRN must be available in the facility.~~ (3-15-22)

02. Discontinued and Expired Prescriptions. Discontinued or outdated medications and treatments must be removed from the resident's medication supply and cannot accumulate at the facility for longer than thirty (30) days. The unused medication must be disposed of ~~in a manner that ensures it cannot be retrieved~~ properly. The facility ~~may enter into agreement, a copy of which must be maintained, with a pharmacy or other authorized entity to return unused, unopened medications for proper disposition. A written record of all drug disposals must be maintained in the facility and include~~ must document the following: ~~(3-15-22)~~( )

a. A description of the drug, including the amount; (3-15-22)

b. Name of the resident for whom the medication is prescribed; (3-15-22)

c. The ~~reason for~~ method and date of disposal; and ~~(3-15-22)~~( )

~~**d.** The method of disposal; (3-15-22)~~

~~**e.** The date of disposal; and (3-15-22)~~

~~**f**~~**d.** Signatures of responsible facility personnel and witness. (3-15-22)

03. **Controlled Substances**. The facility must track all controlled substances entering the facility, including the amount received, the date, a daily count, reconciliation of the number given or disposed, and the number remaining. (3-15-22)

04. ~~**Psychotropic or**~~ **Behavior Modifying Medication**. ~~(3-15-22)~~( )

a. Psychotropic or behavior modifying medication intervention must not be the first resort to address behaviors. The facility must attempt non-drug interventions to assist and redirect the resident's behavior. (3-15-22)

~~**b.** Psychotropic or behavior modifying medications must be prescribed by a physician or authorized provider. (3-15-22)~~

~~**c**~~**b.** The facility must ~~monitor the resident to determine continued need for the medication based on the resident's demonstrated behaviors~~ document residents' response to the medications including demonstrated behaviors and any side effects that impacted the residents' health or safety. ~~(3-15-22)~~( )

c. The facility must provide behavior updates to the physician or authorized provider when requested. ( )

~~**d.** The facility must monitor the resident for any side effects that could impact the resident's health and safety. (3-15-22)~~

~~**e.** The use of psychotropic or behavior modifying medications must be reviewed by the physician or authorized provider at least every six (6) months. The facility must provide behavior updates to the physician or authorized provider to help facilitate an informed decision on the continued use, and possible reduction, of the psychotropic or behavior modifying medication. (3-15-22)~~

311. -- 31~~8~~9. (RESERVED)

~~**319. COMPREHENSIVE ASSESSMENT REQUIREMENTS.**~~
~~The facility must complete assessment information as described in Subsections 319.01 through 319.04 of this rule, prior to admitting the resident to the residential assisted living facility. The remainder of the comprehensive assessment must be completed within fourteen (14) days of admission. Comprehensive assessment information must be updated when there is a change, or at least every twelve (12) months. The comprehensive assessment must contain the following: (3-15-22)~~

~~**01. Resident Demographics**. Resident demographic information, including: (3-15-22)~~

~~**a.** Date of birth; (3-15-22)~~

~~**b.** Placement history; (3-15-22)~~

~~**c.** Identification of any medical diagnoses, including any information about specific health problems, such as allergies, that may be useful in a medical emergency; (3-15-22)~~

~~**d.** Prescription and over the counter medications and treatments; (3-15-22)~~

~~**c.** Information related to cognitive function; (3-15-22)~~

~~**f.** Legal status, to include copies of legal documents when applicable (e.g., guardianship or power of attorney); and (3-15-22)~~

~~**g.** Names and contact information of representatives and emergency contacts. (3-15-22)~~

~~**02. Level of Personal Assistance Required**. The facility must assess the level of assistance required to help the resident with the following: Activities of daily living, including bathing, dressing, toileting, grooming, eating, communicating, medications, and the use of adaptive equipment, such as hearing aids, walkers, or eyeglasses. (3-15-22)~~

~~**03. Nursing Assessment**. Information related to the resident's health, medical status, and identification of any health services needed, including frequency and scope. (3-15-22)~~

~~**04. Maladaptive Behaviors**. Evaluation of maladaptive behaviors, including: (3-15-22)~~

~~**a.** The resident's behavioral history, including any history of traumatic events; (3-15-22)~~

~~**b.** The intensity, duration, and frequency of each maladaptive behavior; (3-15-22)~~

~~**c.** Potential contributing environmental factors, such as heat, noise, or overcrowding; (3-15-22)~~

~~**d.** Any specific events that can trigger maladaptive behaviors; (3-15-22)~~

~~**e.** Potential contributing health factors, such as hunger, pain, constipation, infection, fever, or medication side effects; and (3-15-22)~~

~~**f.** Recent changes in the resident's life, such as a death in the family or changes in care. (3-15-22)~~

~~**05. Resident Preferences**. Resident preferences and historical information that includes: (3-15-22)~~

~~**a.** Religion and church attendance, including preferred church contact information; (3-15-22)~~

~~**b.** Historical information including significant life events, family, work, and education; and (3-15-22)~~

~~**c.** Hobbies or preferred activities. (3-15-22)~~

~~**06. Outside Services**. Information related to outside services, including the service type being provided, when, and by whom. (3-15-22)~~

~~**07. Assessment Results**. The results of the comprehensive assessment must be used to develop the NSA, identify training needs for staff, and evaluate the ability of an administrator and facility to meet the identified resident's needs. (3-15-22)~~

320. NEGOTIATED SERVICE AGREEMENT (NSA) REQUIREMENTS.

~~Under Section 39-3309, Idaho Code, each resident must enter into an NSA completed, signed, and implemented no later than fourteen (14) calendar days from the date of admission.~~ An interim plan must be developed and used while the NSA is being completed ~~as described in Section 330 of these rules~~. ~~(3-15-22)~~( )

~~**01. Use of NSA**. The NSA provides for the coordination of services and instruction to the facility staff. Upon completion, the agreement must clearly identify the resident, describe services to be provided, the frequency of such services, and how such services are to be delivered. (3-15-22)~~

~~**02. Key Elements of the NSA**. A resident's NSA must be based on the comprehensive assessment information described in Section 319 of these rules. NSAs must incorporate information from the resident's care record, described in Section 330 of these rules. (3-15-22)~~

~~03. Signature, Date, and Approval of Agreement. The administrator, resident, and any legal representative must sign and date the NSA upon its completion. (3-15-22)~~

~~04. Review Date. The NSA must include the next scheduled date of review. (3-15-22)~~

~~05. Development of the NSA. The resident, and other relevant persons as identified by the resident, must be included in the development of the NSA. Licensed and professional staff must be involved in the development of the NSA as applicable. (3-15-22)~~

~~06. Copy of Initial Agreement. Signed copies of the agreement must be given to the resident, their representative, and their legal guardian or conservator, and a copy placed in the resident's record, no later than fourteen (14) calendar days from admission. (3-15-22)~~

~~07. Resident Choice. A resident must be given the choice and control of how and what services the facility or external vendors will provide, to the extent the resident can make choices. The resident's choice must not violate the provisions of Section 39-3307(1), Idaho Code. (3-15-22)~~

~~08. Periodic Review. The NSA must be reviewed when there is a change in a diagnosis for a resident or other change in condition requiring different, additional, or replacement services, or at least every twelve (12) months. (3-15-22)~~

321. -- 329. (RESERVED)

330. REQUIREMENTS FOR FACILITY RECORDS.

The facility must ~~maintain complete, accurate, and authentic records which are preserved in a safe location protected from fire, theft, and water damage~~ develop policies and procedures in accordance with Sections 39-3316, Idaho Code, for a minimum of three (3) years. ~~(3-15-22)~~( )

01. Paper Records. All paper records must be recorded legibly in ink. (3-15-22)

~~02. Electronic Records. Electronic records policies and procedures must be developed and implemented that specify which records will be maintained electronically. Policy development and implementation must ensure: (3-15-22)~~

~~a. The facility must print and provide paper copies of electronic records upon the request of the resident, their legal guardian or conservator, advocacy and protection agencies, and the Department. (3-15-22)~~

~~b. Security measures must be taken to protect the use of an electronic signature by anyone other than the person to which the electronic signature belongs and to protect that person's identity. The policy must specify how passwords are assigned, and the frequency they are changed. (3-15-22)~~

~~c. Security measures must be taken to ensure the integrity of any electronic documentation. (3-15-22)~~

0~~3~~2. **Record Confidentiality**. The facility must ~~safeguard confidential information against loss, destruction, and unauthorized use~~ comply with the Health Insurance Portability and Accountability Act (HIPAA). ~~(3-15-22)~~( )

043. **Resident Care Records**. ~~An~~ Each resident must have an individual care record ~~must be maintained for each resident with all entries kept current~~. Entries must be documented during each shift and completed by the person providing the care, including the date, time, name, and title of the person making the entry. ~~(3-15-22)~~( )

~~a. Entries must include the date, time, name, and title of the person making the entry. Staff must sign each entry made by them during their shift. (3-15-22)~~

~~b~~a. ~~Care records of all current residents~~The plan of care must be available to staff at all times. and include: ~~(3-15-22)~~( )

~~c. In addition to an NSA, as described in Section 320 of these rules, each care record must include documentation of the following:~~ ~~(3-15-22)~~

~~i. Comprehensive assessments, as described in Section 319 of these rules;~~ ~~(3-15-22)~~

i~~i~~. ~~Current medications, treatments, and diet prescribed, all signed and dated by the ordering physician or authorized provider~~A copy of written, signed, and dated medication and treatment orders; ~~(3-15-22)~~( )

ii~~i~~. Treatments, wound care, assistance with medications, and any ~~other~~ delegated nursing tasks. ~~Documentation must include any~~ PRN medication use (if applicable), including the reason for taking the medication and the efficacy; ~~(3-15-22)~~( )

iv~~ii~~. ~~Times the NSA is not followed, such as during refusal of care or services. This includes any time a medication is refused by a resident, not taken by a resident, not given to a resident, and the reason for the omission~~Documentation when the resident refuses care or services or the resident missed taking prescribed medication including the reason; ~~(3-15-22)~~( )

~~v. Calls to the resident's physician or authorized provider, including the reason for each call and the outcome;~~ ~~(3-15-22)~~

v~~i~~iv. Notification to the facility nurse of changes in the resident's physical or mental condition; (3-15-22)

v~~ii~~. Nursing assessments~~, as described in Section 305 of these rules~~; ~~(3-15-22)~~( )

vi~~ii~~. The results of any physician or authorized provider visits, including phone calls to providers including the reason and outcome; ~~(3-15-22)~~( )

~~ix~~vii. Copies of all signed and dated care plans prepared by outside service agencies; (3-15-22)

~~x~~viii. Notes regarding outside services and care provided to the resident, such as home health, hospice, or physical therapy; (3-15-22)

~~xi~~ix. Unusual events such as incidents, accidents, or altercations, and the facility's response; and (3-15-22)

x~~ii~~. ~~When a resident refuses medical treatment or physician's orders, the facility must document the resident and their legal guardian have been informed of the consequences of the refusal and the resident's physician or authorized provider has been notified of the refusal~~Documentation the physician, authorized, and legal representative provider has been contacted when a resident consistently refuses medical treatment or physician orders. ~~(3-15-22)~~( )

~~05. Admission Records. As described in Section 39-3315, Idaho Code, resident admission documentation must include:~~ ~~(3-15-22)~~

~~a. The resident's preferred providers and contact information, including physician or authorized provider, optometrist, dentist, pharmacy, and outside service providers.~~ ~~(3-15-22)~~

~~b. Results of the resident's last history and physical examination, performed by a physician or authorized provider. The examination must have been conducted no more than six (6) months prior to admission.~~ ~~(3-15-22)~~

~~c. Physician or authorized provider orders that are current, signed, and dated, including a list of medications, treatments, diet, and any limitations.~~ ~~(3-15-22)~~

~~d. A written admission agreement that is signed and dated by the administrator and the resident or~~

~~their legal guardian or conservator, and meets the requirements of Section 216 of these rules.~~ ~~(3-15-22)~~

~~e.~~ ~~If separate from the admission agreement, a copy of the payment schedule and fee structure signed and dated by the resident or their legal guardian or conservator.~~ ~~(3-15-22)~~

~~f.~~ ~~If the facility manages the resident's funds, a signed and dated written agreement between the facility and the resident or their legal guardian or conservator that specifies the terms.~~ ~~(3-15-22)~~

~~g.~~ ~~A signed copy of the resident's rights, as described in Sections 550 and 560 of these rules, or a signed and dated statement that the resident or their legal guardian or conservator has read and understands their rights in a residential assisted living facility.~~ ~~(3-15-22)~~

~~h.~~ ~~An interim care plan signed by the resident, responsible party, and the facility, completed prior to, or on the day of, admission.~~ ~~(3-15-22)~~

~~i.~~ ~~Documentation indicating the resident has been informed of the facility's emergency procedures, including resident responsibility.~~ ~~(3-15-22)~~

0~~6~~4. **Behavior Documentation**. For residents who exhibit maladaptive behaviors,~~ behavior management records must be maintained in the resident record, including~~ the facility must maintain documentation of the following: ~~(3-15-22)~~( )

a. An assessment of maladaptive behaviors~~, as described in Section 319 of these rules~~. ~~(3-15-22)~~( )

b. A behavior plan that includes~~ at least one (1)~~ intervention~~ specific to each maladaptive behavior~~.s; ~~(3-15-22)~~( )

i. Interventions must be the least restrictive possible~~;~~ and must include the date and time of each maladaptive behavior, a description of the behavior, the interventions implemented and the effectiveness of each intervention. ~~(3-15-22)~~( )

~~ii. Each intervention must be reviewed as appropriate, based on the severity of the behavior, to evaluate the effectiveness and continued need for the intervention.~~ ~~(3-15-22)~~

~~c.~~ ~~Ongoing tracking of behaviors, including documentation of the date and time each maladaptive behavior was observed, the specific behavior that was observed, what interventions were used in response to the maladaptive behavior, and the effectiveness of each intervention.~~ ~~(3-15-22)~~

0~~7~~5. **Discharge Records**. Resident discharge documentation must include: (3-15-22)

a. ~~When the discharge is involuntary, the facility's efforts to resolve the situation and a copy of the discharge notice, signed and dated by the resident and the facility. If the resident refuses, or is unable to sign the notice, the facility must maintain evidence that the notice was delivered to the resident and the responsible party~~A copy of the written notice of discharge if applicable; ~~(3-15-22)~~( )

b. The date and the location where the resident~~ is~~ was discharged; and ~~(3-15-22)~~( )

c. The disposition of the resident's belongings. (3-15-22)

0~~8~~6. **Additional Resident Records**. The facility must also maintain the following for each resident: (3-15-22)

a. A record of all resident personal property~~ that the resident has entrusted to the facility, including documentation to identify and track the property to ensure that personal items are kept safe and used only by the resident to which the items belong~~ with a value of more than fifty dollars ($50); and ~~(3-15-22)~~( )

b. ~~Any~~A record of complaints or grievances ~~voiced by the resident~~ including the date received, the investigation ~~with~~ and the outcome~~, and the response to the resident~~. ~~(3-15-22)~~( )

0~~9~~7. **Resident Admission and Discharge Register**. The facility must maintain an admission and discharge register listing the name of each resident, the date admitted, and the date discharged. ~~The admission and discharge register must be produced as a separate document, apart from resident records, and kept current.~~ ~~(3-15-22)~~( )

~~**10. Hourly Adult Care Documentation**. A log of those who have utilized hourly adult care must be maintained, including the dates the service was provided. Individual records must be maintained for each person utilizing hourly adult care. The individual record documentation must include:~~ ~~(3-15-22)~~

~~**a.** Admission identification information, including contact information for the responsible party in an emergency, and the physician or authorized provider;~~ ~~(3-15-22)~~

~~**b.** Information, such as medical and social, relevant to the supervision of the person; and~~ ~~(3-15-22)~~

~~**c.** Care and services provided during hourly adult care, including assistance with medications.~~ ~~(3-15-22)~~

~~11~~08. **Dietary Records**. The facility must maintain on-site a minimum of three (3) months of dietary ~~documentation, as follows~~ records including: ~~(3-15-22)~~( )

a. ~~Copies of planned menus, including therapeutic menus, that are approved, signed, and dated by a dietitian; and~~Planned, substitution, and therapeutic menus that have been approved and signed by a dietitian. ~~(3-15-22)~~( )

~~**b.** Served menus, including therapeutic menus, which reflect substitutions made.~~ ~~(3-15-22)~~

09. Water Supply. Laboratory reports documenting the bacteriological examination of a private water supply. ( )

~~**12. Records for Water Supply**. Copies of laboratory reports documenting the bacteriological examination of a private water supply must be kept on file in the facility.~~ ~~(3-15-22)~~

1~~3~~0. **Personnel Records**. A record for each employee must be maintained and available, which includes the following: (3-15-22)

a. The employee's name, address, phone number, and date of hire; (3-15-22)

b. A job description that includes the purpose, responsibilities, duties, and authority; (3-15-22)

~~**c.** Evidence that on, or prior to hire, staff were notified in writing if the facility does or does not carry professional liability insurance. If the facility cancels existing professional liability insurance, all staff must be notified of the change in writing;~~ ~~(3-15-22)~~

~~d~~c. A copy of a ~~current~~ valid license for ~~all~~ nursing staff ~~and verification from the Board of Nursing that the license is in good standing with identification of restrictions~~; ~~(3-15-22)~~( )

~~e~~d. Signed ~~evidence of training as described in Sections 620 through 641 of these rules~~ and dated record of all required staff training; ~~(3-15-22)~~( )

~~f~~e. Copies of CPR and first aid certifications; (3-15-22)

~~g~~f. Evidence of medication training ~~as described in Section 645 of these rules~~; ~~(3-15-22)~~( )

~~h~~g. Criminal history and background check results ~~that meet Section 009 of these rules and state-only~~

~~background check results~~; ~~(3-15-22)~~( )

~~i~~h. Documentation by the licensed nurse of delegation to unlicensed staff ~~who assist residents with medications and other nursing tasks~~; ~~(3-15-22)~~( )

~~j~~i. ~~When acting on behalf of the administrator, a signed document authorizing the responsibility~~A signed and dated record identifying any administrator or manager designees; and ~~(3-15-22)~~( )

~~k~~j. ~~Copies~~Records of contracts with outside service providers and contract staff. ~~(3-15-22)~~( )

141. **As Worked Schedules**. Work records ~~must be maintained in written or electronic format which reflect:~~ indicating direct care staff names and shifts worked. ~~(3-15-22)~~( )

~~a. Personnel on duty, at any given time; and~~ ~~(3-15-22)~~

~~b. The first and last names of each employee and their position.~~ ~~(3-15-22)~~

153. **Fire and Life Safety Records**. The administrator must ensure the facility's records for fire and life safety are maintained. The facility must maintain on file: (3-15-22)

a. ~~Fire~~The results of fire detection, alarm~~, and communication system reports~~ inspections, maintenance, and test results including: ~~(3-15-22)~~( )

i. The results of the annual inspection and tests; and (3-15-22)

ii. Smoke detector sensitivity testing results. (3-15-22)

b. The results of any ~~weekly, monthly, quarterly, semi-annual, and annual~~ sprinkler system inspections, maintenance, and tests; ~~(3-15-22)~~( )

c. ~~Records of the m~~Monthly examination of ~~the~~ portable fire extinguishers, including initials and date and documenting the following: ~~(3-15-22)~~( )

~~i. Each extinguisher is in its designated location;~~ ~~(3-15-22)~~

i~~i~~. Each extinguisher seal or tamper indicator is not broken; (3-15-22)

ii~~i~~. Each extinguisher has not been physically damaged; (3-15-22)

~~iv~~iii. Each extinguisher gauge shows a charged condition; and (3-15-22)

~~v. The inspection tag or documentation for the extinguisher must show at least the initials of the person making the monthly examination and the date of the examination.~~ ~~(3-15-22)~~

~~d. Documentation for when a fire watch is instituted and a fire watch log for each round of patrol, identifying who conducted the fire watch, date, time, and situations encountered.~~ ~~(3-15-22)~~

331. -- 334. (RESERVED)

335. REQUIREMENTS FOR INFECTION CONTROL.
The ~~administrator is responsible for ensuring that~~ facility must develop policies and procedures consistent with recognized standards that control and prevent infections for both staff and residents ~~are developed and implemented throughout the facility, to include:~~. ~~(3-15-22)~~( )

01. **Staff with an Infectious Disease**. Staff with an infectious disease must not work until the infectious stage no longer exists or must be reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent. (3-15-22)

02. Standard Precautions. Standard precautions for infection prevention must be ~~used in the care of residents to prevent transmission of infectious disease according to~~ in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. ~~These guidelines may be accessed on the CDC website at http://www.cdc.gov/hai/~~. ~~(3-15-22)~~( )

03. Reporting of Individual with an Infectious Disease. ~~The name of any resident or facility personnel with a reportable disease listed in~~ Facilities must report any cases of resident or staff illness consistent with the diseases listed in IDAPA 16.02.10, "Idaho Reportable Diseases~~:~~.~~"~~ ~~must be reported immediately to the local health district authority with appropriate infection control procedures immediately implemented as directed by that local health authority~~ The facility must follow guidance from local health districts. ~~(3-15-22)~~( )

336. -- ~~399~~404. (RESERVED)

~~400. REQUIREMENTS FOR FIRE AND LIFE SAFETY STANDARDS.~~
~~A facility's buildings must meet all requirements of the local and state codes that are applicable to residential assisted living facilities for fire and life safety standards. Facilities' evacuation capability is considered "impractical" as defined by NFPA, Standard 101.~~ ~~(3-15-22)~~

~~401. FIRE AND LIFE SAFETY STANDARDS FOR NEW BUILDINGS HOUSING THREE THROUGH SIXTEEN RESIDENTS.~~
~~A newly constructed facility, change of ownership, or a building converted to a residential assisted living facility on or after January 1, 2021, housing three (3) to sixteen (16) residents on the first story only must comply with NFPA, Standard 101, Chapter 32, Small Facilities.~~ ~~(3-15-22)~~

~~402. FIRE AND LIFE SAFETY STANDARDS FOR NEW BUILDINGS HOUSING SEVENTEEN OR MORE RESIDENTS AND MULTI STORY BUILDINGS.~~
~~A newly constructed facility, change of ownership, or a building converted to a residential assisted living facility on or after January 1, 2021, housing seventeen (17) residents or more, or any building housing residents on stories other than the first story must comply with requirements of NFPA, Standard 101, Chapter 32, Large Facilities.~~ ~~(3-15-22)~~

~~403. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR THREE THROUGH SIXTEEN RESIDENTS.~~
~~Existing facilities licensed prior to January 1, 2021, housing three (3) to sixteen (16) residents on the first story only, must comply with the requirements of the NFPA, Standard 101, Chapter 33, Small Facilities. Existing buildings that are not sprinklered may continue to operate, except when Section 401 of these rules apply.~~ ~~(3-15-22)~~

~~404. FIRE AND LIFE SAFETY STANDARDS FOR EXISTING BUILDINGS LICENSED FOR SEVENTEEN OR MORE RESIDENTS AND MULTI STORY BUILDINGS.~~
~~Existing facilities licensed prior to January 1, 2021 housing seventeen (17) or more residents and multi-story buildings or any building housing residents on stories other than the first story must comply with NFPA, Standard 101, Chapter 33, Large Facilities.~~ ~~(3-15-22)~~

405. ADDITIONAL FIRE AND LIFE SAFETY STANDARDS FOR ALL BUILDINGS AND FACILITIES.

~~01. Electrical Installations and Equipment~~. ~~Electrical installations and equipment must comply with applicable local or state electrical requirements in NFPA, Standard 101, Mandatory References.~~ ~~(3-15-22)~~

~~**a.** Extension cords and multi-plug adapters are prohibited;~~ ~~(3-15-22)~~

~~**b.** Relocatable Power Taps (RPTs) must be Underwriter Laboratories (U/L) approved with the following requirements:~~ ~~(3-15-22)~~

~~i. RPTs must be directly connected to a wall outlet; and~~ ~~(3-15-22)~~

~~ii. Have a built-in surge protector.~~ ~~(3-15-22)~~

~~02. Prohibited Applications. The following are prohibited uses of an RPT: (3-15-22)~~

~~a. Medical equipment; (3-15-22)~~

~~b. Daisy chain or plugging one (1) plug strip into a second plug strip; (3-15-22)~~

~~c. Appliances; (3-15-22)~~

~~d. As a convenience, in lieu of permanent installed receptacles; and (3-15-22)~~

~~e. Extend through walls, ceilings, floors, under doors or floor coverings, or be subject to environmental or physical damage. (3-15-22)~~

0~~3~~1. **Medical Gases**. Handling, use, and storage of medical gas must be according to ~~NFPA, Standard 99, Chapter 11, Performance, Maintenance, and Testing as referenced in Section 004 of these rules~~ local fire code standards. ~~(3-15-22)~~( )

~~04. Fuel-Fired Heating. Fuel-fired heating devices and systems must be inspected, serviced, and cleaned at least annually by a person professionally engaged in the business of servicing these devices or systems. (3-15-22)~~

0~~5~~2. **Natural or Man-Made Hazards**. When natural or man-made hazards are present on the facility property or border the facility property, suitable fences, guards, railing, or a combination must be installed to provide protection for the residents. (3-15-22)

0~~6~~3. **Telephone**. The facility must have a telephone on the premises available for staff use in the event of an emergency. Emergency telephone numbers must be posted near the telephone. (3-15-22)

04. **Prohibited Applications**. The following are prohibited uses of a Relocatable Power Tap. ( )

a. Medical equipment; ( )

b. Daisy chain or plugging one (1) plug strip into a second plug strip; ( )

c. Appliances; ( )

d. As a convenience, in lieu of permanent installed receptacles; and ( )

e. Extend through walls, ceilings, floors, under doors or floor coverings, or be subject to environmental or physical damage. ( )

406. -- 409. (RESERVED)

410. REQUIREMENTS FOR EMERGENCY ACTIONS AND FIRE DRILLS.

Fire drills must be conducted ~~not less than six (6) times a year on a bimonthly basis, with not less than two (2) conducted during the night when residents are sleeping. Records must be maintained on file at the facility and contain a description, date, and time of the drill, response of the personnel and residents, problems encountered, and recommendations for improvement~~ quarterly and at least one per shift per year and include date and time of drill including personnel and residents involved. ~~(3-15-22)~~( )

01. Report of Fire. ~~A separate report on each fire incident occurring within the facility must be submitted to the Licensing Agency~~ Any fire or fire incident occurring within the facility must be reported to the Department within ~~thirty~~ fifteen (~~30~~15) days of the occurrence. ~~The reporting form, "Facility Fire Incident Report," issued by the Licensing Agency is used to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any.~~ A fire incident is considered any activation of the building's fire alarm system other than a false alarm, during testing of the fire alarm system, or during a fire drill. ~~(3-15-22)~~( )

02. Fire Watch. Where a required fire alarm system or fire sprinkler system is out of service for more than four (4) hours in a twenty-four (24) hour period, the ~~authority having~~ local jurisdiction must be notified, and the building evacuated, or an approved and documented fire watch provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. ~~(3-15-22)~~( )

411. -- 429. (RESERVED)

430. REQUIREMENTS FOR FURNISHINGS, EQUIPMENT, AND SUPPLIES~~, AND BASIC SERVICES~~.
Each facility must provide ~~to the resident~~: ~~(3-15-22)~~( )

01. Common Shared Furnishings. ~~Appropriately designed and constructed furnishings to meet the needs of each resident, including reading lamps, tables, comfortable chairs, or sofas. All items must be in good repair, clean, safe, and provided at no additional cost to the resident~~ Common areas must be furnished with appropriate reading lamps, tables, chairs, or sofas that are clean, safe, and in good repair. ~~(3-15-22)~~( )

02. Resident Sleeping Room Furnishings. ~~Comfortable furnishings and individual storage, such as a dresser, for personal items for each resident in each sleeping room.~~ All ~~items~~ facility provided furnishings such as a dresser, or bed, must be in good repair, clean, and safe. Resident beds shall be at least thirty-six (36) inches wide. ~~(3-15-22)~~( )

~~**03. Resident Bed**. Each resident must be provided their own bed, which will be at least thirty-six (36) inches wide, substantially constructed, clean, and in good repair. Roll-away beds, cots, futons, folding beds, or double bunks are prohibited. Bed springs must be in good repair, clean, and comfortable. Bed mattresses must be standard for the bed, clean, and odor-free. A pillow must be provided.~~ ~~(3-15-22)~~

043. Resident Telephone Privacy. The facility must have at least one (1) telephone that is accessible to all residents, and provide local calls at no additional cost. The telephone must be placed in such a manner as to provide the resident privacy while using the telephone. (3-15-22)

054. Basic Services. ~~The following are basic services to be provided to the resident by the facility within the basic services rate:~~ Basic services and personal supplies must be provided in accordance with the admission agreement. ~~(3-15-22)~~( )

~~**a.** Rent; (3-15-22)~~

~~**b.** Utilities; (3-15-22)~~

~~**c.** Food; (3-15-22)~~

~~**d.** Activities of daily living services; (3-15-22)~~

~~**e.** Supervision; (3-15-22)~~

~~**f.** First aid; (3-15-22)~~

~~**g.** Assistance with and monitoring of medications; (3-15-22)~~

~~**h.** Laundering of linens owned by the facility; (3-15-22)~~

~~**i.** Emergency interventions and coordination of outside services; (3-15-22)~~

~~**j.** Routine housekeeping and maintenance of common areas; and (3-15-22)~~

~~**k.** Access to basic television in common areas. (3-15-22)~~

~~06. Basic Supplies. The following are to be supplied by the facility at no additional cost to the resident: linens, towels, wash cloths, liquid hand soap, non-sterile exam gloves, toilet paper, and first aid supplies, unless the resident chooses to provide their own. (3-15-22)~~

~~07. Personal Supplies. Soap, shampoo, hair brush, comb, electric razor or other means of shaving, toothbrush, toothpaste, sanitary napkins, and incontinence supplies must be provided by the facility unless the resident chooses to provide their own. The facility may charge the resident for personal supplies the facility provides and must itemize each item being charged to the resident. (3-15-22)~~

~~08. Resident Supplies and Furnishings. If a resident chooses to provide their own supplies or furnishings, the facility must ensure that the resident's supplies or furnishings meet the minimum standards as identified in this rule. (3-15-22)~~

431. -- 449. (RESERVED)

450. REQUIREMENTS FOR FOOD AND NUTRITIONAL CARE SERVICES.
The facility food services must meet the standards in IDAPA 16.02.19, "Idaho Food Code~~,~~." ~~as incorporated in Section 004 of these rules. The facility must also implement operational policies for providing proper nutritional care for each resident, which includes procedures to follow if the resident refuses food or to follow a prescribed diet.~~ ~~(3-15-22)~~( )

451. MENU AND DIET PLANNING.
~~The facility must provide each resident with at least the minimum food and nutritional needs in accordance with the Recommended Dietary Allowances established by the Food and Nutrition Board of the National Academy of Sciences. These recommendations are found in the Idaho Diet Manual incorporated by reference in Section 004 of these rules. The menu must be adjusted for age, sex, and activity as approved by a registered dietitian. (3-15-22)~~

01. Menu. ~~The facility must have a menu~~ Must be planned ~~or~~ approved, ~~and~~ signed, and dated by a registered dietitian ~~prior to being served to any resident. The planned menu must meet nutritional standards~~.
~~(3-15-22)~~( )

a. Menus will provide a sufficient variety of foods in adequate amounts at each meal; (3-15-22)

~~**b.** Food selections must include foods that are served in the community and in season. Food selections and textures should account for residents' preferences, food habits, and physical abilities. (3-15-22)~~

~~**e**~~**b.** The ~~current~~ weekly menu must be posted in a facility common area; and ~~(3-15-22)~~( )

~~**d**~~**c.** The facility must serve the planned menu. If substitutions are made, the menu must be modified to reflect the substitutions. (3-15-22)

02. Therapeutic Diets. ~~The facility must have a therapeutic diet menu~~ Therapeutic menus must be planned ~~or~~, approved, ~~and~~ signed, and dated by a registered dietitian ~~prior to being served to any resident~~.
~~(3-15-22)~~( )

~~**a.** The therapeutic diet planned menu, if possible, must meet nutritional standards; (3-15-22)~~

~~**b.** The therapeutic diet menu must be planned as close to a regular diet as possible; and (3-15-22)~~

~~**c.** The facility must have for each resident on a therapeutic diet, an order from a physician or authorized provider. (3-15-22)~~

~~**03. Facilities Licensed for Sixteen Beds or Less**. In facilities licensed for sixteen (16) beds or less, menus must be planned in writing at least one (1) week in advance. (3-15-22)~~

~~**04. Facilities Licensed for Seventeen Beds or More**. Facilities licensed for seventeen (17) beds or more must: (3-15-22)~~

~~a. Develop and implement a cycle menu which covers a minimum of two (2) seasons and is four (4) to five (5) weeks in length;~~ (3-15-22)

~~b. Follow standardized recipes; and~~ (3-15-22)

~~c. Have available in the kitchen a current copy of the Idaho Food Code and Idaho Diet Manual.~~ (3-15-22)

452. -- 454. (RESERVED)

455. FOOD SUPPLY.
The facility must maintain a seven (7) day supply of nonperishable foods and a two (2) day supply of perishable foods. The facility's kitchen must have the types and amounts of food to be served readily available to meet all planned menus during that time. (3-15-22)

456. -- 459. (RESERVED)

460. FOOD PREPARATION AND SERVICE.

01. Food Preparation. Foods must be prepared by methods that conserve nutritional value, flavor, and appearance. (3-15-22)

02. Frequency ~~of Meals~~. ~~Food must be offered throughout the day, as follows:~~ Meals must be served at least three (3) times per day at regular intervals with snacks and fluids offered between meals. ~~(3-15-22)~~( )

~~a. To provide residents at least three (3) meals daily, at regular times comparable to normal mealtimes in the community;~~ (3-15-22)

~~b. To ensure no more than fourteen (14) hours between a substantial evening meal and breakfast;~~ (3-15-22)

~~c. Ensure that residents who are not in the facility for the noon meal are offered a substantial evening meal; and~~ (3-15-22)

~~d. Offer snacks and fluids between meals and at bedtime.~~ (3-15-22)

~~03. Food Preparation Area~~. ~~Any areas used for food preparation must be maintained as follows:~~ (3-15-22)

~~a. No live animals or fowl will be kept or maintained in the food service preparation or service area; and~~ (3-15-22)

~~b. Food preparation and service areas cannot be used as living quarters for staff.~~ (3-15-22)

0~~4~~3. Disposable Items. The facility will not use single-use items except in unusual circumstances for a short period of time or for special events. (3-15-22)

461. -- ~~509.~~ ~~(RESERVED)~~

~~510. REQUIREMENTS TO PROTECT RESIDENTS FROM ABUSE.~~
~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from abuse. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request.~~ (3-15-22)

~~511. -- 514. (RESERVED)~~

~~515. REQUIREMENTS TO PROTECT RESIDENTS FROM EXPLOITATION.~~
~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from exploitation. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request.~~ ~~(3-15-22)~~

~~516. – 519. (RESERVED)~~

~~520. REQUIREMENTS TO PROTECT RESIDENTS FROM INADEQUATE CARE.~~
~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from inadequate care. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request.~~ ~~(3-15-22)~~

~~521. – 524. (RESERVED)~~

~~525. REQUIREMENTS TO PROTECT RESIDENTS FROM NEGLECT.~~
~~The administrator must ensure that policies and procedures are developed and implemented to ensure that all residents are free from neglect. These policies and procedures should be posted in a conspicuous place in the facility, shared with new residents, families upon admission, all residents annually thereafter, and made available upon request.~~ ~~(3-15-22)~~

~~526. –~~ 599. (RESERVED)

600. REQUIREMENTS FOR STAFFING STANDARDS.
The ~~administrator~~ facility must develop ~~and implement written staffing~~ policies and procedures ~~based on the number of residents, resident needs, and configuration of the facility,~~ for staffing to ensure adequate care is provided to residents which include: ~~(3-15-22)~~( )

01. On-Duty Staff Up and Awake During Residents' Sleeping Hours. ~~Qualified and trained s~~Staff must be up and awake, and immediately available in the facility during resident sleeping hours. ~~(3-15-22)~~( )

02. Detached Buildings or Units. Facilities with ~~residents housed in~~ detached buildings or units must have at least one (1) staff present and available in each building ~~or unit when residents are present in the building or unit. The facility must also ensure that each building or unit complies with the requirements for on-duty staff during resident sleeping hours to be up, awake, and immediately available in accordance with the facility's licensed bed capacity as provided in this rule. The Licensing Agency will consider a variance based on the facility's written submitted plan of operation~~ when residents are present. ~~(3-15-22)~~( )

~~**03. Personnel Management**. The administrator is responsible for the management of all personnel to include contract personnel.~~ ~~(3-15-22)~~

~~**04. Sufficient Personnel**. As described in Section 39-3322, Idaho Code, the facility will employ and the administrator will schedule sufficient personnel to:~~ ~~(3-15-22)~~

~~**a.** Provide care and supervision, during all hours, as required in each resident's NSA, to ensure residents' health, safety, and comfort, and to ensure the interior and exterior of the facility is maintained in a safe and clean manner; and~~ ~~(3-15-22)~~

~~**b.** To provide for at least one (1) direct care staff with certification in first aid and cardio-pulmonary resuscitation (CPR) in the facility at all times. Facilities with multiple buildings or units will have at least one (1) direct care staff with certification in first aid and CPR in each building or each unit at all times.~~ ~~(3-15-22)~~

03. Cardio-Pulmonary Resuscitation (CPR) and First Aid Certification. Provide for at least one (1) direct care staff with certification in first aid and CPR in the facility at all times. Facilities with multiple buildings or units will have at least one (1) direct care staff with certification in first aid and CPR in each building or each unit at

all times. ( )

601. --~~619.~~ ~~(RESERVED)~~

~~620. REQUIREMENTS FOR TRAINING OF FACILITY PERSONNEL.~~
~~The facility must follow structured, written training programs designed to meet the training needs of personnel in relation to responsibilities, as specified in the written job description, to provide for quality of care and compliance with these rules. Signed evidence of personnel training, indicating hours and topic, must be retained at the facility.~~
~~(3-15-22)~~

~~621. —~~ 624. (RESERVED)

625. ORIENTATION TRAINING REQUIREMENTS.
~~The administrator must ensure that each staff member~~Staff must complete~~s~~ orientation training specific to their job description as described in Section 39-3324, Idaho Code~~. Staff who have not completed the orientation training requirements must work with a staff who has completed the orientation training~~, within thirty (30) days of hire. Prior to working alone staff must have completed the orientation training requirements. ~~(3-15-22)~~( )

01. Number of Hours of Training. A minimum of sixteen (16) hours of job-related orientation training must be ~~provided to all new personnel before they are allowed to provide~~ completed prior to providing unsupervised personal assistance to residents. The means and methods of training are at the facility's discretion.
~~(3-15-22)~~( )

~~02. Timeline for Completion of Training~~~~. All orientation training must be completed within thirty (30) days of hire.~~ ~~(3-15-22)~~

0~~3~~2. Content for Training. Orientation training must include the following: (3-15-22)

~~a.~~ ~~The philosophy of residential assisted living and how it guides caregiving;~~ ~~(3-15-22)~~

~~b~~a. Resident rights; (3-15-22)

~~c.~~ ~~Cultural awareness;~~ ~~(3-15-22)~~

~~d.~~ ~~Providing personal assistance;~~ ~~(3-15-22)~~

~~e.~~ ~~How to respond to emergencies;~~ ~~(3-15-22)~~

~~f~~b. Reporting and documentation requirements for~~ resident care records, incidents, accidents, complaints, and~~ allegations of abuse, neglect, and exploitation; ~~(3-15-22)~~( )

~~g.~~ ~~Identifying and reporting changes in residents' health or mental condition;~~ ~~(3-15-22)~~

~~h.~~ ~~Advance directives and do not resuscitate (DNR) orders;~~ ~~(3-15-22)~~

~~i~~c. Relevant policies and procedures; and ~~(3-15-22)~~( )

~~j.~~ ~~The role of the NSA; and~~ ~~(3-15-22)~~

~~k.~~ ~~All staff employed by the facility, including housekeeping personnel and contract personnel, must be trained in infection control procedures for universal precautions.~~ ~~(3-15-22)~~

d. Training must be specific and appropriate to the population served. ( )

626. --~~629.~~ ~~(RESERVED)~~

630. TRAINING REQUIREMENTS FOR FACILITIES ADMITTING RESIDENTS WITH A DIAGNOSIS OF DEMENTIA, MENTAL ILLNESS, DEVELOPMENTAL DISABILITY, OR TRAUMATIC BRAIN INJURY.

A facility admitting and retaining residents with a diagnosis of dementia, mental illness, developmental disability, or traumatic brain injury must train all staff to meet the specialized needs of these residents. Staff must receive specialized training within thirty (30) days of hire or of admission of a resident with one (1) of these conditions. The means and methods of training are at the facility's discretion. The training should address the following areas: (3-15-22)

01. Dementia: (3-15-22)

a. Overview of dementia; (3-15-22)

b. Symptoms and behaviors of people with memory impairment; (3-15-22)

c. Communication with people with memory impairment; (3-15-22)

d. Resident's adjustment to the new living environment; (3-15-22)

e. Behavior management, including the consistent implementation of behavior interventions; (3-15-22)

f. Activities of daily living; and (3-15-22)

g. Stress reduction for facility personnel and the resident. (3-15-22)

02. Mental Illness: (3-15-22)

a. Overview of mental illnesses; (3-15-22)

b. Symptoms and behaviors specific to mental illness; (3-15-22)

c. Resident's adjustment to the new living environment; (3-15-22)

d. Behavior management, including the consistent implementation of behavior interventions; (3-15-22)

e. Communication; (3-15-22)

f. Activities of daily living; (3-15-22)

g. Integration with rehabilitation services; and (3-15-22)

h. Stress reduction for facility personnel and the resident. (3-15-22)

03. Developmental Disability: (3-15-22)

a. Overview of developmental disabilities; (3-15-22)

b. Interaction and acceptance; (3-15-22)

c. Promotion of independence; (3-15-22)

d. Communication; (3-15-22)

e. Behavior management, including the consistent implementation of behavior interventions; (3-15-22)

~~f. Assistance with adaptive equipment; (3-15-22)~~

~~g. Integration with rehabilitation services; (3-15-22)~~

~~h. Activities of daily living; and (3-15-22)~~

~~i. Community integration. (3-15-22)~~

~~04. Traumatic Brain Injury: (3-15-22)~~

~~a. Overview of traumatic brain injuries; (3-15-22)~~

~~b. Symptoms and behaviors specific to traumatic brain injury; (3-15-22)~~

~~c. Adjustment to the new living environment; (3-15-22)~~

~~d. Behavior management, including the consistent implementation of behavior interventions; (3-15-22)~~

~~e. Communication; (3-15-22)~~

~~f. Integration with rehabilitation services; (3-15-22)~~

~~g. Activities of daily living; (3-15-22)~~

~~h. Assistance with adaptive equipment; and (3-15-22)~~

~~i. Stress reduction for facility personnel and the resident. (3-15-22)~~

~~631. --~~ 639. (RESERVED)

640. CONTINUED TRAINING REQUIREMENTS.
Each employee must receive a minimum of eight (8) hours of job-related continued training per year. (3-15-22)

641. ADDITIONAL TRAINING RELATED TO CHANGES.
When policies or procedures are added, modified, or deleted, the date of the change must be specified on the policy and staff training must ~~receive additional training related to the changes~~ be updated. ~~(3-15-22)~~( )

642. -- 644. (RESERVED)

645. ASSISTANCE WITH MEDICATIONS.

01. Training Requirements. ~~To provide assistance with medications, staff must have the following training requirements, and be delegated as described in this rule.~~ Prior to assisting residents with medications, staff must complete the following: ~~(3-15-22)~~( )

a. ~~Before staff can begin assisting residents with medications, successful completion of a~~A medication assistance course offered by one (1) of Idaho's community colleges~~. This training is not included as part of the minimum of sixteen (16) hours of orientation training or minimum of eight (8) hours of continued training per year~~ or a curriculum approved by the Department. This training is in addition to the curriculum minimum orientation requirements. ~~(3-15-22)~~( )

b. Staff training on documentation requirements and how to respond when a resident refuses or misses a medication, receives an incorrect medication, or when medication is unavailable or missing. (3-15-22)

02. Delegation. The facility nurse must delegate and document assistance with medications and other

nursing tasks. Each medication assistant must be delegated individually, including skill demonstration, prior to assisting with medications or nursing tasks, and any time the licensed nurse changes. (3-15-22)

646. -- 899. (RESERVED)

900. ENFORCEMENT ACTIONS.
Enforcement actions, as described in ~~Sections 901 through 940 of~~ these rules and Sections 39-3357 and 39-3358, Idaho Code, are actions the Department can impose upon a facility. The Department will consider a facility's compliance history, ~~change(s) of ownership,~~ and the number, scope, and severity of the deficiencies when initiating or extending an enforcement action. The Department can impose any of the enforcement actions, independently or in conjunction with others. ~~(3-15-22)~~( )

901. ENFORCEMENT ACTION ~~OF SUMMARY SUSPENSION~~.
~~When the Department finds that the facility's deficient practice(s) immediately place the health or safety of any residents in danger, the Department may take immediate action through summary suspension of the facility's license, the imposition of temporary management, a limit on admissions, and transfer the residents~~If the Department determined non-compliance with these rules immediately jeopardizes the health or safety of residents the Department may take action in accordance with Section 39-3358, Idaho Code. ~~(3-15-22)~~( )

902. -- 909. (RESERVED)

910. ENFORCEMENT ACTION OF A CONSULTANT.
A consultant may be required when an acceptable plan of correction has not been submitted, ~~as described in Section 130 of these rules,~~ or if the Department identifies repeat deficient practice(s) in the facility. The consultant is required to submit periodic reports to the Licensing Agency. ~~(3-15-22)~~( )

911. -- 919. (RESERVED)

920. ENFORCEMENT ACTION OF LIMIT ON ADMISSIONS.

01. Reasons for Limit on Admissions. The Department may limit admissions for the following reasons: (3-15-22)

a. The facility is inadequately staffed or the staff is inadequately trained to handle more residents; (3-15-22)

b. The facility otherwise lacks the resources necessary to support the needs of more residents; (3-15-22)

c. The Department identifies repeat core issues during any follow-up survey; ~~and~~ or ~~(3-15-22)~~( )

d. An acceptable plan of correction is not submitted as described in Section ~~130 of these rules~~ 39-3352, Idaho Code. ~~(3-15-22)~~( )

02. Notification of Limit on Admissions. ~~The Department will notify the facility of the limit on admissions of residents (e.g., a full ban of admissions, a limit of admissions based on resident diagnosis, etc.) pending the correction of deficient practice(s).~~ Limits or bans on admissions ~~to the facility~~ will remain in effect until the Department determines the facility has achieved ~~full~~ substantial compliance with requirements or receives written evidence and statements from the outside consultant that the facility is in compliance. ~~(3-15-22)~~( )

921. -- 924. (RESERVED)

925. ENFORCEMENT ACTION OF CIVIL MONETARY PENALTIES.

~~**01. Civil Monetary Penalties**. May be issued when a facility is operating without a license, repeat deficiencies are identified, or the facility fails to comply with conditions of the provisional license. Actual harm to a resident or residents does not need to be shown. A single act, omission, or incident will not give rise to imposition of~~

~~multiple penalties, even though such act, omission, or incident may violate more than one (1) rule.~~ ~~(3-15-22)~~

01. Civil Monetary Penalties. May be imposed when it is determined a facility is operating without a license, has repeat non-core deficiencies that place residents at significant risk for potential harm, or the facility fails to comply with conditions of the provisional license. Actual harm to a resident or residents does not need to occur. A single act, omission, or incident will not give rise to imposition of multiple penalties, even though such act, omission, or incident may violate more than one (1) rule.

02. Assessment Amount for Civil Monetary Penalty. ~~When c~~ Civil monetary penalties are ~~imposed, such penalties are~~ assessed at ten dollars ($10) for each day the facility is or was out of compliance~~. The amounts below are~~ per deficiency, multiplied by the total number of occupied licensed beds ~~according to the records of the Department at the time non-compliance is established~~. ~~(3-15-22)~~( )

~~**a.** Repeat deficiency is ten dollars ($10). Example below:~~

~~Number of Occupied Beds in Facility~~	~~Repeat Deficiency~~	~~Times Number of Days Out of Compliance~~	~~Amount of Penalty~~
~~11~~	~~$10.00~~	~~30 days~~	~~$3,300~~

~~(3-15-22)~~

~~**b**~~**a.** In any ninety (90) day period, the penalty amounts may not exceed the limits shown in the following table:

Limits on Accruing Civil Monetary Amount	
Number of Occupied Beds in Facility	**Repeat Deficiency**
3-4 Beds	$2,880
5-50 Beds	$6,400
51-100 Beds	$10,800
101-150 Beds	$17,600
151 or More Beds	$29,200

(3-15-22)

03. Notice of Civil Monetary Penalties and Appeal Rights. The Department will give written notice informing the facility of the amount of the penalty, the basis for its assessment and the facility's appeal rights. (3-15-22)

04. Payment of Penalties. The facility must pay the full amount of the penalty within thirty (30) calendar days from the date the notice is received, unless the facility requests an administrative review ~~of the decision to assess the penalty~~. The ~~amount of a~~ civil monetary penalty determined through administrative review must be paid within thirty (30) calendar days of the ~~facility's receipt of the~~ dated administrative review decision, unless the facility requests an administrative hearing. The amount of the civil monetary penalty determined through an administrative hearing must be paid within thirty (30) calendar days of the ~~facility's receipt of the administrative~~ dated hearing decision unless the facility files a petition for judicial review. Interest accrues on all unpaid penalties at the legal rate of interest for judgments. Such interest accruement will begin one (1) calendar day after the date of the initial assessment of the penalty. ~~(3-15-22)~~( )

05. Failure to Pay. Failure of a facility to pay the entire penalty, together with any interest, is cause for revocation of the license or the amount will be withheld from Medicaid payments to the facility. (3-15-22)

926. -- 929. (RESERVED)

930. ENFORCEMENT ACTION OF TEMPORARY MANAGEMENT.

01. Need for Temporary Management. The Department may impose, and appoint the ~~action of~~ use of temporary management in situations where ~~there is a need to oversee operation of the facility and to ensure the health and safety of the facility's residents~~ it is determined there is immediate jeopardy to the health and safety of the residents, such as: ~~(3-15-22)~~( )

a. ~~During an orderly transfer of residents of the facility to other facilities~~To ensure the safe relocation of residents due to a facility closure; or ~~(3-15-22)~~( )

b. A temporary manager is necessary to bring the facility back into substantial compliance ~~P~~pending improvements to bring the facility into compliance with program requirements. ~~(3-15-22)~~( )

~~**02. Notice of Temporary Management**. The Department will give written notice to the facility of the imposition of temporary management. (3-15-22)~~

~~**03. Who May Serve as a Temporary Manager**. The Department may appoint any person or organization that meets the following qualifications: (3-15-22)~~

~~**a.** The temporary manager must not have any financial interest in the facility to be managed; (3-15-22)~~

~~**b.** The temporary manager must not be related, within the first degree of kinship, to the facility's owner, manager, administrator, or other management principal; (3-15-22)~~

~~**c.** The temporary manager must possess sufficient training, expertise, and experience in the operation of a facility as would be necessary to achieve the objectives of temporary management. If the temporary manager is to serve in a facility, the manager must possess an Residential Assisted Living Administrator's license; and (3-15-22)~~

~~**d.** The temporary manager must not be an existing competitor of the facility who would gain an unfair competitive advantage by being appointed as temporary manager of the facility. (3-15-22)~~

0~~4~~2. Powers and Duties of the Temporary Manager. The temporary manager ~~has the authority to direct and oversee the management, and to hire and discharge any consultant or personnel, including the administrator of the facility. The temporary manager has the authority to direct the expenditure of the revenues of the facility in a reasonable and prudent manner, to oversee the continuation of the business and the care of the residents, to oversee and direct those acts necessary to accomplish the goals of the program requirements, and to direct and oversee regular accounting. When the facility fails or refuses to carry out the directions of the temporary manager, the Department may revoke the facility's license~~ will have the authority to direct and oversee the day-to-day operations of the facility including the enforcement of policies and procedures and ensuring the facility is in compliance with these rules. ~~(7-1-24)~~( )

~~**a.** The temporary manager must observe the confidentiality of the operating policies, procedures, employment practices, financial information, and all similar business information of the facility, except that the temporary manager must make reports to the Department; (3-15-22)~~

~~**b.** The temporary manager may be liable for gross, willful or wanton negligence, intentional acts of omissions, unexplained shortfalls in the facility's fund, and breaches of fiduciary duty; (3-15-22)~~

~~**c.** The temporary manager does not have authority to cause or direct the facility, its owner, or administrator to incur debt, unless to bring the facility into compliance with these rules, or to enter into any contract with a duration beyond the term of the temporary management of the facility; (3-15-22)~~

~~**d.** The temporary manager does not have authority to incur, without the permission of the owner, administrator, or the Department, capital expenditures in excess of two thousand dollars ($2,000), unless the capital~~

~~expenditures are directly related to correcting the identified deficiencies;~~ ~~(3-15-22)~~

~~**c.** The temporary manager does not have authority to cause or direct the facility to encumber its assets or receivables;~~ ~~(3-15-22)~~

~~**f.** The temporary manager does not have authority to cause or direct a facility, which holds liability or casualty insurance coverage, to cancel or reduce its liability or casualty insurance coverage; and~~ ~~(3-15-22)~~

~~**g.** The temporary manager does not have authority to cause or direct the sale of the facility, its assets or the premises on which it is located.~~ ~~(3-15-22)~~

0~~5~~3. **Responsibility for Payment of the Temporary Manager**. All compensation and per diem costs of the temporary manager must be paid by the licensee. (3-15-22)

~~**06. Termination of Temporary Management**. A temporary manager may be replaced under the following conditions:~~ ~~(3-15-22)~~

~~**a.** The Department may require replacement of any temporary manager whose performance is deemed unsatisfactory by the Department. No formal procedure is required for such removal or replacement, but written notice of any action will be given to the facility.~~ ~~(3-15-22)~~

~~**b.** A facility subject to temporary management may petition the Department for replacement of a temporary manager whose performance it considers unsatisfactory. The petition must include why the replacement of a temporary manager is necessary or appropriate.~~ ~~(3-15-22)~~

931. -- 934. (RESERVED)

935. ENFORCEMENT ACTION OF A PROVISIONAL LICENSE.
A provisional license may be issued when a facility has one (1) or more core issues, when non-core issues have not been corrected, have become repeat deficiencies, or an acceptable plan of correction is not submitted as described in these rules. The provisional license will state the conditions the facility must follow to continue to operate. (3-15-22)

936. --~~939.~~ ~~(RESERVED)~~

~~940. ENFORCEMENT ACTION OF REVOCATION OF FACILITY LICENSE.~~

~~**01. Revocation of Facility's License**. The Department may revoke a license when the facility endangers the health or safety of residents, or when the facility is not in substantial compliance with the provisions of Title 39, Chapter 33, Idaho Code, or this chapter of rules.~~ ~~(3-15-22)~~

~~**02. Reasons for Revocation or Denial of a Facility License**. The Department may revoke or deny any facility license for any of the following reasons:~~ ~~(3-15-22)~~

~~**a.** The licensee has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license;~~ ~~(3-15-22)~~

~~**b.** When persuaded by a preponderance of the evidence that such conditions exist which endanger the health or safety of any resident;~~ ~~(3-15-22)~~

~~**c.** Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person or persons in charge of the facility. Such acts may include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, criminal activity, or exploitation;~~ ~~(3-15-22)~~

~~**d.** The licensee has demonstrated or exhibited a lack of sound judgment essential to the operation and management of a facility;~~ ~~(3-15-22)~~

~~**e.** The licensee has violated any of the conditions of a provisional license;~~ ~~(3-15-22)~~

~~f. The facility lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of residents residing at the facility; (3-15-22)~~

~~g. Licensee refuses to allow the Department or the protection and advocacy agencies full access to the facility environment, facility records, and the residents as described in Sections 130 and 550 of these rules; (3-15-22)~~

~~h. The licensee has been guilty of fraud, gross negligence, abuse, assault, battery, or exploitation with respect to the operation of a health facility, residential assisted living facility, or certified family home; (3-15-22)~~

~~i. The licensee is actively affected in their performance by alcohol or the use of drugs classified as controlled substances; (3-15-22)~~

~~j. The licensee has been convicted of a criminal offense other than a minor traffic violation within the past five (5) years; (3-15-22)~~

~~k. The licensee is of poor moral and responsible character or has been convicted of a felony or defrauding the government; (3-15-22)~~

~~l. The licensee has been denied, or the licensee's wrong doing has caused the revocation of any license or certificate of any health facility, residential assisted living facility, or certified family home; (3-15-22)~~

~~m. The licensee has previously operated any health facility or residential assisted living facility without a license or certified family home without a certificate; (3-15-22)~~

~~n. The licensee is directly under the control or influence of any person who has been the subject of proceedings as described in this rule; (3-15-22)~~

~~o. The licensee is directly under the control or influence of any person who is of poor moral and responsible character or has been convicted of a felony or defrauding the government; (3-15-22)~~

~~p. The licensee is directly under the control or influence of any person who has been convicted of a criminal offense other than a minor traffic violation in the past five (5) years; (3-15-22)~~

~~q. The licensee fails to pay civil monetary penalties imposed by the Department as described in Section 925 of these rules; (3-15-22)~~

~~r. The licensee fails to take sufficient corrective action as described in Section 130 of these rules; or (3-15-22)~~

~~s. The number of residents currently in the facility exceeds the number of residents the facility is licensed to serve. (3-15-22)~~

~~941. —~~ **999. (RESERVED)**

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.26 – MEDICAID PLAN BENEFITS

DOCKET NO. 16-0326-2501 (NEW CHAPTER)

NOTICE OF RULEMAKING – TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1st, 2025.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), and 56-265, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 9, 2025 **11:00 AM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mfb6f2909a7d17e7447618fe97f63eac7** **Join by meeting number** **Meeting number (access code): 2822 338 6614** **Meeting password: 26Fi2shtJsu** **Meeting password when dialing from a phone or video system: 26342748** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Friday, June 20, 2025 **1:00 PM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m8dde786d6ef5bc0caca430062852921f** **Join by meeting number** **Meeting number (access code): 2828 200 3736** **Meeting password: 9DJvRvv8MX9** **Meeting password when dialing from a phone or video system: 93587888** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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

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

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review and consolidation of existing chapters to streamline or simplify this rule language. IDAPA 16.03.09 and 16.03.10 were two of several rule chapters eliminated in House Bill 345 during the 2025 Idaho Legislative Session, which is set to take effect July 1st, 2025. The Department has combined components of both 16.03.09, Medicaid Basic Plan Benefits, and 16.03.10, Medicaid Enhanced Plan Benefits, into a single document which is proposed to be entitled 16.03.26 Medicaid Plan Benefits and take effect the same day the existing rules were set to expire.

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

House Bill 345 of the 2025 Idaho Legislative Session overwhelmingly passed both chambers of the state legislature and was signed by the governor. The final provisions of this bill eliminated several chapters of administrative rule related to Medicaid including both 16.03.09 and 16.03.10. It was made clear to both legislators and stakeholders that if this bill became law, that the Department would stand back up portions of the effected rules via temporary rule by July 1st, 2025.

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

Fees will not be increased as a result of this rulemaking.

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

There is not anticipated to be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted on 16.03.10 which has been folded into this temporary and proposed combined document. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, Volume 25-4, pages 23 and 24.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25th, 2025.

DATED this 2nd day of May, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
DHWRules@dhw.idaho.gov

THE FOLLOWING IS THE TEMPORARY RULE AND THE PROPOSED TEXT OF DOCKET NO. 16-0326-2501
(New Chapter)

16.03.26 – MEDICAID PLAN BENEFITS

000. LEGAL AUTHORITY.
The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), and 56-265, Idaho Code. (7-1-25)T

001. SCOPE.
These rules contain the general provisions regarding the administration of Medicaid. All goods and services not specifically included in this chapter are excluded from coverage under Medicaid Benefit Plans. These rules also contain requirements for provider procurement and reimbursement. Individuals eligible for the Medicaid Enhanced Plan, including those enrolled in a duals managed care plan, also receive all Medicaid Basic Plan benefits. (7-1-25)T

002. INCORPORATION BY REFERENCE.

01. Estimated Useful Lives of Depreciable Hospital Assets, 2023 Revised Edition. The document may be obtained from the American Hospital Association, 155 North Wacker Drive, Ste. 400, Chicago, IL, 60606. (7-1-25)T

02. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (7-1-25)T

003. BACKGROUND CHECK REQUIREMENTS.

01. Background Check Compliance. Background checks are required for specific providers under these rules. Providers who are required to have a background check and their contractors must comply with IDAPA 16.05.06. (7-1-25)T

02. Department-Issued Variances. (7-1-25)T

a. The Department may allow variances to clearance requirements under certain circumstances. Applicable providers must still complete an application for a background check. (7-1-25)T

b. Applicants with prior convictions for disqualifying drug and alcohol-related offenses may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services. (7-1-25)T

03. Subsequent Convictions, Charges, or Investigations. Once clearances are received, any subsequent criminal, adult, or child protection convictions, charges, or investigations must be immediately reported by the agency to the Department once known. (7-1-25)T

04. Providers Subject to Background Check Requirements. (7-1-25)T

a. Adult Day Health Agencies. (7-1-25)T

b. Behavior Consultation or Crisis Management Providers. (7-1-25)T

c. Chore Services Providers. (7-1-25)T

d. Contracted Non-Emergency Medical Transportation (NEMT) Providers, with direct contact with participants except for Individual Contracted NEMT providers. (7-1-25)T

e. Independent CHIS Providers. ()

f. Non-Medical Transportation (NMT) Providers. (7-1-25)T

g. Personal Assistance Agencies (PAA), including PAAs Acting as Fiscal Intermediaries. (7-1-25)T

h. Provider types deemed by the Department to be at high risk for fraud, waste, or abuse. (7-1-25)T

i. Respite Care Providers. (7-1-25)T

j. Service Coordination Agencies. (7-1-25)T

k. Supported Employment Agencies. (7-1-25)T

004. (RESERVED)

005. DEFINITIONS: A THROUGH H.

01. Activities of Daily Living (ADL). Basic self-care activities that meet an individual's needs to sustain them in a daily living environment, and includes bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (7-1-25)T

02. Agency. A business entity comprised of an administrator and their employees providing a Medicaid service. Individuals cannot be an agency. (7-1-25)T

03. Adult Day Health (ADH). Defined in Section 67-5006(5), Idaho Code, as adult day care. (7-1-25)T

04. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (7-1-25)T

05. Audit. An examination of provider records and financial records to determine compliance with Medicaid requirements and regulations or quality assurance. (7-1-25)T

06. Budget Adjustment Factor (BAF). Total budget for nursing facility (NF) payment established by the Idaho legislature effective on July 1 annually and compared to the annual expected Medicaid rates for the same rate year. BAF may be positive or negative and applies to all NF rates calculated under the established prospective rate system. BAF is not applied to the calculated customary charge for each NF nor applied to any retrospectively settled NF. (7-1-25)T

07. Case Mix Adjustment Factor. Factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The facility-wide acuity is the average of the indexes corresponding to the cost reporting period. (7-1-25)T

08. Case Mix Index (CMI). Numeric score assigned to each facility resident, based on their physical and mental condition projecting the relative resources needed to provide their care. (7-1-25)T

a. Facility-Wide CMI. Average of the entire facility's CMIs identified at each picture date during the cost reporting period. If CMIs are unavailable for applicable quarters due to lack of data, CMIs from available quarters are used. (7-1-25)T

b. Medicaid CMI. Average of the weighting factors assigned to each Medicaid resident in a facility on

the picture date, based on their RUG classification. Medicaid status is based upon information contained in the MDS databases. When Medicaid identifiers are found to be incorrect, the Department adjusts the Medicaid CMI and reestablishes the rate. (7-1-25)T

c. State-Wide Average CMI. Simple average of all facilities "facility-wide" CMIs used to establish the rate limitation July 1st of each year. (7-1-25)T

09. Children's Habilitation Intervention Services (CHIS). CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. (7-1-25)T

10. Children's Health Insurance Program (CHIP). Medical assistance for children under Idaho's Title XXI State Plan. The term Medicaid for the purposes of this rule apply to CHIP. (7-1-25)T

11. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (7-1-25)T

12. CMS. Centers for Medicare and Medicaid Services. (7-1-25)T

13. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-25)T

14. Customary Charges. The rates charged to Medicare participants and other paying patients as reflected in the facility's records. Charges are adjusted downward, when the provider does not hold most patients liable for payment on a charge basis or, when there are not reasonable collection efforts. Reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM. (7-1-25)T

15. Day Treatment Services. Developmental services provided regularly during normal working hours on weekdays by, or on behalf of, an ICF/IID that do not include recreational, speech, physical, or occupational therapy, or other services paid for, or required to be provided by, a school or other entity. (7-1-25)T

16. Department. The Idaho Department of Health and Welfare or its designee. (7-1-25)T

17. Director. The Director of the Department or their designee. (7-1-25)T

18. Developmental Disability (DD). As defined in Section 66-402(5), Idaho Code. (7-1-25)T

19. Dual Eligible. Participants eligible for Medicaid under IDAPA 16.03.05, when their eligibility is not provided solely under the Woman Diagnosed with Breast or Cervical Cancer program, and who are enrolled in both Medicare Parts A and B. (7-1-25)T

20. Durable Medical Equipment (DME). Equipment and appliances that are not orthotics or prosthetics; are primarily and customarily used to serve a medical purpose; are generally not useful to an individual in the absence of a disability, illness, or injury; can withstand repeated use; can be reusable or removable; and are suitable for use in any setting in which normal life activities take place. (7-1-25)T

21. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services. Medically necessary services are health care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether such services are covered under the State Plan. (7-1-25)T

22. Educational Services. Services provided online, in buildings or areas designated for use as a school or educational setting; provided during time periods in which educational instruction takes place in the school day; included in a participant's individual educational plan for school age individuals. (7-1-25)T

23. Evidence-Based Interventions. Interventions that have been scientifically researched and

reviewed in peer-reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model (EBM). (7-1-25)T

24. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual, who are not certified or credentialed in an EBM. (7-1-25)T

25. Facility. Facility refers to a hospital, nursing facility (NF), or intermediate care facility for individuals with intellectual disabilities (ICF/IID). (7-1-25)T

26. Fiscal Intermediary. An entity that provides services allowing the participant receiving personal assistance services, their designee or legal representative, to choose their level of control for recruiting, selecting, managing, training, and dismissing their personal assistant regardless of the employer of record, and allows the participant control over the way services are delivered. (7-1-25)T

27. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include, but are not limited to, sociology, special education, counseling, psychology, or other areas of academic study as referenced in the Medicaid Provider Handbook. (7-1-25)T

006. DEFINITIONS: I THROUGH O.

01. Idaho Medicaid Provider Handbook. A document that contains policy for the implementation and operations of the Medicaid program. (7-1-25)T

02. In-State Care. Medical services not including long-term care provided within Idaho or in counties bordering Idaho. (7-1-25)T

03. Inspection of Care Team (IOCT). Interdisciplinary team providing inspection of care in licensed ICFs/IID composed of: (7-1-25)T

a. An RN; and (7-1-25)T

b. A QIDP; and when required, a: (7-1-25)T

i. Consultant physician; (7-1-25)T

ii. Consultant social worker; or (7-1-25)T

iii. When appropriate, other health and human services employees or consultants of the Department. (7-1-25)T

04. Instrumental Activities of Daily Living (IADL). Activities performed to support ADL, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, communicating, or accessing the community. (7-1-25)T

05. Integration. Promoting a lifestyle for home and community-based service (HCBS) participants like other community members, including those living in and accessing community resources to enhance the social image and personal competence of HCBS participants. (7-1-25)T

06. Interim Reimbursement Rate (IRR). Rate paid for each Medicaid patient day intended to result in total Medicaid payments approximating the amount paid at audit settlement and intended to include any payments allowed over the percentile cap. (7-1-25)T

07. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An entity licensed as an ICF/IID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (7-1-25)T

08. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (7-1-25)T

09. Level of Support. Amount of services and supports necessary to allow a participant to live independently and safely in the community, as derived from a Department-approved assessment tool. (7-1-25)T

10. Licensed Bed Capacity. Number of beds approved by the State's Licensure and Certification Agency for rendering patient care. (7-1-25)T

11. Lower of Cost or Charges. Payment to providers (other than public providers furnishing services free of charge or at nominal charges to the public) that is the lesser of the reasonable cost of services or customary charges of like services. Public providers furnishing services free of charge or at a nominal charge are reimbursed fair compensation; considered reasonable cost. (7-1-25)T

12. Major Movable Equipment. Major movable equipment as defined in Section 56-101(16), Idaho Code, that also has a unit cost of five thousand dollars ($5,000) or more. (7-1-25)T

13. Medicaid-Related Ancillary Costs. Services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs are determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, is considered Medicaid-related ancillaries. (7-1-25)T

14. Medical Assistance (Medicaid). Payments for part or all of the cost of services, capitation payments, or managed care costs funded by Titles XIX or XXI of the federal Social Security Act (SSA). (7-1-25)T

15. Medical Necessity (Medically Necessary). A service is medically necessary if: (7-1-25)T

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; (7-1-25)T

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly; (7-1-25)T

c. It meets any applicable Department criteria. Services that do not meet criteria require a PA; (7-1-25)T

d. Medical services must be of a quality that meets professionally recognized standards of health care, and is substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (7-1-25)T

16. Medical, Social, and Developmental Assessment (MSDA) Summary. Form used by the Department to gather a participant medical, social, and developmental history and other summary information required for all DD HCBS program participants under a service plan used to assess and authorize services. (7-1-25)T

17. Medical Supplies. Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-25)T

18. Minimum Data Set (MDS). Set of screening, clinical, and functional status elements, including common definitions and coding categories, forming the foundation of a comprehensive assessment for all residents of long-term care facilities certified under Medicare or Medicaid. Updated versions of the MDS are evaluated and incorporated into rate setting as necessary. (7-1-25)T

19. Minor Movable Equipment. Minor movable equipment as defined in Section 56-101(18), Idaho

Code, with a unit cost under five thousand dollars ($5,000.) (7-1-25)T

20. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (7-1-25)T

21. Order. Written instructions from a healthcare professional acting within the scope of their practice for a participant's treatment, medications, tests or procedures. Orders shall include: (7-1-25)T

a. Participant's name; (7-1-25)T

b. Description of item or service; (7-1-25)T

c. Length of need, if applicable; (7-1-25)T

d. Quantity, if applicable; (7-1-25)T

e. Provider's name, National Provider Identification (NPI) and signature; and (7-1-25)T

f. Date of signature. (7-1-25)T

22. Ordinary. Costs incurred that are customary for normal operation of a business. (7-1-25)T

23. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (7-1-25)T

007. DEFINITIONS: P THROUGH Z.

01. Participant. A person eligible for and enrolled in Medicaid. (7-1-25)T

02. Personal Assistance Agency (PAA). An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (7-1-25)T

03. Plan Developer. A service coordinator identified by the participant responsible for developing a service plan and subsequent addenda covering all services and supports, based on a person-centered planning process. A plan developer may be paid, unpaid or the unpaid participant themselves. (7-1-25)T

04. Plan Monitor. A person who oversees service delivery on a paid or non-paid basis. For DD services, the plan monitor is a service coordinator. (7-1-25)T

05. Plan of Care. A written description of medical, remedial, habilitative, or rehabilitative services to provide to a participant, developed by or under the direction and written approval of a provider. Medications, services, and treatments shall be identified specifically by amount, type, and duration of service. (7-1-25)T

06. Primary Care Provider (PCP). A healthcare professional acting within the scope of their practice, who is the first point of contact for routine medical concerns. (7-1-25)T

07. Prior Authorization (PA). PA means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. (7-1-25)T

08. Property Rental Rate. Rate paid per Medicaid patient day to free-standing facilities in lieu of payment for property costs other than property taxes, insurance, and costs of major movable equipment. (7-1-25)T

09. Prosthetic Device. Replacement, corrective, or supportive devices to: (7-1-25)T

a. Artificially replace a missing portion of the body; (7-1-25)T

b. Prevent or correct physical deformities or malfunctions; or (7-1-25)T

c. Support a weak or deformed portion of the body. (7-1-25)T

d. Computerized communication devices are not included in this definition. (7-1-25)T

10. Provider. Any individual acting under Section 020 including, but not limited to certified registered nurse anesthetists, nurse practitioners, nurse midwives, clinical nurse specialists, pharmacists, physician assistants, and physicians. Alternatively, a partnership, association, corporation, or organization that furnishes medical goods or services in compliance with these rules. (7-1-25)T

11. Provider Status Review. Written documentation identifying a participant's progress toward goals defined in their service plan. (7-1-25)T

12. Qualified Intellectual Disabilities Professional (QIDP). As described in 42 CFR 483.430(a). (7-1-25)T

13. Quality Improvement Organization (QIO). An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. (7-1-25)T

14. Recoupment. As detailed in IDAPA 16.05.07. (7-1-25)T

15. Recreational Services. Activities that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties. (7-1-25)T

16. Referral. A documented recommendation from a healthcare professional to see another Medicaid provider for a specific service. (7-1-25)T

17. Related Entity. An organization associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (7-1-25)T

18. Resource Utilization Groups (RUG). Process to group residents according to the clinical and functional status identified by responses to key elements of the MDS and used for rate setting and determining NF level of care. (7-1-25)T

19. Restrictive Intervention. Any intervention that is used to restrict rights or freedom of movement and includes chemical restraint, mechanical restraint, physical restraint, and seclusion. (7-1-25)T

20. Retrospective Review. A review of an item or service after it has been provided. The review determines medical necessity and conformity to Medicaid requirements. Claims that have already received payment may be subject to recoupment. (7-1-25)T

21. Rural Hospital-Based Behavioral Care Unit. A Rural Hospital-Based Provider that qualifies as a behavioral care unit. (7-1-25)T

22. Service Coordination. Case management activity to assist participants with gaining and coordinating access to necessary care and services appropriate to their needs. (7-1-25)T

23. Service Plan. An initial or annual plan that identifies all services and supports based on a person-centered planning process and authorized by the Department. (7-1-25)T

24. Skilled Nursing Care. Level of care for patients requiring twenty-four (24) hour skilled nursing services. (7-1-25)T

25. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (7-1-25)T

26. Supports. Services that provide supervision and assistance to a participant or facilitates integration into the community. (7-1-25)T

27. Third Party. Includes a person, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant. (7-1-25)T

28. Utilization Control (UC). Program of prepayment screening and annual review by the Department determining the appropriateness of and the need for continued medical entitlement of applicants or participants in a NF. (7-1-25)T

29. Utilization Control Team (UCT). Team of Regional nurse reviewers that conducts on-site reviews of the care and services in NFs approved by the Department as Medicaid providers. (7-1-25)T

30. Vocational Services. Services directly related to the preparation for paid or unpaid employment. Vocational services are provided with the expectation a participant will participate in a sheltered workshop or the general workforce within a year. (7-1-25)T

008. – 009. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 010-019)

010. MEDICAL ASSISTANCE PROCEDURES.
The Department will issue a card to eligible participants which will contain their name and Medicaid identification number. When requested, the Department will give providers eligibility information regarding participants. (7-1-25)T

011. CHOICE OF PROVIDERS.
Participants may obtain services available from any participating provider of their choice, unless enrolled in a Managed Care Organization, Prepaid Ambulatory Health Plan, or Prepaid Inpatient Health Plan that limits provider choice, or a lock-in program. This does not prohibit the Department from setting standards relating to the qualifications of providers. (7-1-25)T

012. PARTICIPANT RESPONSIBILITY.
Participants are responsible for keeping appointments with providers. The Department will not reimburse providers when participants do not attend appointments. Providers cannot bill participants for missed appointments. (7-1-25)T

013. – 019. (RESERVED)

GENERAL PROVIDER PROVISIONS
(Sections 020-039)

020. INDIVIDUAL PROVIDER REQUIREMENTS.

01. Provider Eligibility. Be licensed or registered as required by the applicable jurisdiction for the profession, have a National Provider Identification (NPI) or Medicaid provider number, and enter into a written provider agreement with the Department. (7-1-25)T

02. Practice Authority. Provide services within the practice authority for the applicable profession consistent with the laws and regulations of the state where services are provided. (7-1-25)T

03. Standard of Care. Provide services within the accepted standard of care that would be provided in the same or similar setting by a reasonable and prudent provider with similar education, training, and experience as determined by the applicable oversight authority. (7-1-25)T

04. Express Exclusions. Not perform any service that is expressly prohibited by state or federal regulations. Further, no reimbursement will be provided for any service that is expressly excluded for a provider in these rules. (7-1-25)T

021. PROVIDER APPLICATION PROCESS.

01. Application. Providers who meet Medicaid enrollment requirements may apply for provider status with the Department. All providers eligible for an NPI must apply with that number. For providers not eligible for an NPI, the Department will assign a provider number upon approval of the application. (7-1-25)T

02. Disclosure of Information. All enrolling providers and any additional disclosable party must comply with the disclosure requirements in 42 CFR Part 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents." (7-1-25)T

03. Denial of Provider Agreement. The Department may refuse a request to enter into a provider agreement, extend an existing agreement, or enter into additional agreements with any provider. Requests for a provider agreement are denied when: (7-1-25)T

a. The provider fails to meet the qualifications required by rule or by any applicable licensing board. (7-1-25)T

b. The provider was a managing employee, or had an ownership interest, in any entity and: (7-1-25)T

i. Previously found by the Department to have engaged in fraudulent or abusive conduct related to the Medicaid program; or (7-1-25)T

ii. Demonstrated an inability to comply with the requirements related to the provider status for which application is made, including submitting false claims or violating provisions of any provider agreement; (7-1-25)T

c. Failed to repay the Department for any overpayments or improper claims, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law. (7-1-25)T

d. The provider employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in this section. (7-1-25)T

e. The provider is currently suspended or terminated from Medicare or Medicaid in any state. (7-1-25)T

022. PROVIDER AGREEMENTS.
This section applies to all providers including Family-Directed Community Supports (FDCS). ()

01. General. All individuals or entities must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services. Agreements may contain any terms or conditions deemed appropriate by the Department. All provider agreements must be signed by an authorized representative who has the legal authority to bind the provider in the agreement. (7-1-25)T

02. Enforcement Actions and Terminations. The Department may take any of the following actions for cause based on the conduct of the provider, or its employees or agents, or when the provider fails to comply with the provider agreement, or any applicable state or federal regulation: (7-1-25)T

a. Require corrective actions in IDAPA 16.05.07; (7-1-25)T

b. Require a corrective action plan to be submitted by the provider to address noncompliance with requirements; (7-1-25)T

c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; (7-1-25)T

d. Limit or suspend provision of services to participants who have not previously established services

with the provider pending the submission, acceptance, or completion of a corrective action plan; or (7-1-25)T

e. Terminate the provider's agreement. (7-1-25)T

i. The Department may terminate provider agreements with or without cause by giving written notice to the provider as set forth in the agreement. (7-1-25)T

ii. Terminations without cause may result from elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers or will result from the discretionary act of another regulatory body. If an agreement does not provide a notice period, the period is twenty-eight (28) days. (7-1-25)T

iii. Terminations for cause may be appealed. (7-1-25)T

03. Crossover Only Providers. Providers of professional services may enroll as crossover only providers that bill for dual eligible participants' Medicare coinsurance and deductible. Crossover only providers act as non-billing ORPs for all other participants. (7-1-25)T

04. Non-billing Ordering, Referring, and Prescribing (ORP). Providers may enroll as non-billing ORPs, provided they follow the provider application process and sign a provider agreement. Non-billing ORPs are not eligible for reimbursement and are otherwise not Medicaid providers. (7-1-25)T

023. – 024. (RESERVED)

025. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medically necessary services when a complete and properly submitted claim for payment has been received and each of the following conditions are met: (7-1-25)T

a. The participant received services no earlier than the third month before an application was made on the participant's behalf; (7-1-25)T

b. The provider verified the participant's eligibility on the date of service and can provide proof of the eligibility verification; (7-1-25)T

c. Services provided after the participant's date of death cannot be reimbursed; and (7-1-25)T

d. Not more than twelve (12) months have elapsed since the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. When a participant is determined retroactively eligible, the Department will reimburse providers for services within the period of retroactive eligibility, if a claim is submitted within twelve (12) months of the participant's eligibility determination. (7-1-25)T

02. Comply With All Applicable Regulations. (7-1-25)T

03. Comply With the Idaho Medicaid Provider Handbook. (7-1-25)T

04. Acceptance of State Payment. Providers agree to accept as payment in full the amounts paid by the Department for covered services. Participants cannot be billed for covered services. Providers may only bill participants for non-covered services when the participant is notified in writing before the service is provided that it is non-covered and its cost. (7-1-25)T

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (7-1-25)T

06. Ordering, Referring, and Prescribing Providers (ORP). Any service ordered, prescribed, or referred by a provider who is not an enrolled Medicaid provider will not be reimbursed by the Department. (7-1-25)T

07. Referrals. Medicaid services may require a referral. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a required referral, are not covered and are subject to sanctions and recoupment. (7-1-25)T

08. Prior Authorization (PA). The Department may require a PA for any service. Unless otherwise specified: (7-1-25)T

a. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid PA request. An exception may be allowed on a case-by-case basis, when events beyond the provider's control prevented the request's submission. (7-1-25)T

b. The provider cannot bill the Medicaid participant for non-covered services solely because the authorization was not requested or obtained in a timely manner. (7-1-25)T

c. An item or service will be deemed prior approved when the participant was not eligible for Medicaid when the service was provided, but was subsequently determined eligible under IDAPA 16.03.05, or IDAPA 16.03.01, and the medical item or service provided is authorized by the Department. (7-1-25)T

d. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. (7-1-25)T

09. Follow-up Communication. Medicaid services may require timely follow-up communication with the participant's PCP provider as listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication are not covered and subject to sanctions and recoupment. (7-1-25)T

026. THIRD-PARTY LIABILITY.

01. Determining Liability. The Department will take reasonable measures to determine liability of third parties for services rendered to a participant. (7-1-25)T

02. Current Resource. The Department will treat any third-party liability as a current resource when payment by the third-party has been made or will be made within a reasonable time. (7-1-25)T

03. Withholding Payment. The Department will not withhold payment because of the liability of a third party when liability cannot be currently established or available to pay the participant's medical expense. (7-1-25)T

04. Seeking Third-Party Reimbursement. The Department will seek reimbursement from a third party when liability existed, but was not treated as a current resource, with the exceptions provided under this rule. The Department will seek reimbursement from a participant in any situation in which the participant has received direct payment from any third-party and not forwarded the money to the Department for services received. (7-1-25)T

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third-party payment, with the following exceptions: (7-1-25)T

a. When the resource is a court-ordered absent parent and there are no other viable resources available, the claims will be reimbursed, and the resources billed by the Department; (7-1-25)T

b. Preventive pediatric care including early and periodic screening, diagnostic, and treatment services which includes: (7-1-25)T

i. Well Child examinations for children under age twenty-one (21) years when provided according to

guidance in the Idaho Medicaid Provider Handbook; (7-1-25)T

ii. Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms. (7-1-25)T

c. When PA has been approved under these rules, treatment services to control, correct, or ameliorate health problems found through diagnosis and screenings; (7-1-25)T

d. If the claim is for preventative pediatric care under this rule, the Department will make payment for the service provided in its fee schedule and will seek reimbursement from the third party under 42 U.S.C. 1396a(a)(25)(E). (7-1-25)T

06. Accident Determination. When the participant's Medicaid card indicates private insurance or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until third party liability determination can occur. (7-1-25)T

07. Third-Party Payments. The Department will pay the provider the lowest amount of the following: (7-1-25)T

a. The provider's actual charge for the service; (7-1-25)T

b. The maximum allowable charge for the service as established by the Department in its pricing file; or (7-1-25)T

c. The third-party allowed amount minus the third-party payment, or the patient liability as indicated by the third-party. (7-1-25)T

08. Subrogation of Third-Party Liability. In all cases where the Department will be required to pay for a participant who is entitled to recover any medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of Medicaid benefits paid by the Department. (7-1-25)T

a. If litigation or a settlement in such a claim is pursued by the Medicaid participant, the participant must notify the Department. (7-1-25)T

b. If the participant recovers funds from a third party, the participant must repay the amount of benefits paid by the Department. (7-1-25)T

09. Subrogation of Legal Fees. (7-1-25)T

a. If a participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept, will be reduced by the total amount of attorney fees and court costs paid by the participant. (7-1-25)T

b. If a settlement or judgment is received by the participant that does not specify which portion is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses in an amount equal to that paid by the Department. (7-1-25)T

027. – 029. (RESERVED)

030. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (7-1-25)T

a. Providers must obtain the required information from the Electronic Verification System (EVS) by using the Medicaid number on the identification card from the EVS and transfer the required information onto the

appropriate claim form. (7-1-25)T

b. Upon providing the care and services to a participant, the provider or their agent must submit a properly completed claim to the Department including their usual and customary charge, which is the lowest charge by the provider to the general public for the same service including advertised specials. Each claim submitted by a provider constitutes an agreement to accept and abide by the Department's requirements. (7-1-25)T

c. The Department is to process each claim received and make payment directly to the provider. (7-1-25)T

d. The Department will not supply claim forms. Form examples needed to comply with the Department's unique billing requirements are included in the Idaho Medicaid Provider Handbook. (7-1-25)T

02. Provider Reimbursement. (7-1-25)T

a. The Department will pay the provider the lowest of: (7-1-25)T

i. The provider's actual charge for service; or (7-1-25)T

ii. The maximum allowable charge for the service as established by the Department on its pricing file and Idaho Medicaid Provider Handbook; or (7-1-25)T

iii. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (7-1-25)T

b. Services and items without a Medicare price on file are priced for the maximum allowable charge at the Department's discretion per the following: (7-1-25)T

i. Historical cost or regional reimbursement data. (7-1-25)T

ii. Percent of charge. (7-1-25)T

iii. A copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer or wholesaler. Reimbursement will be seventy-five percent (75%) of MSRP or quote. If the pricing documentation is an invoice for items, reimbursement will be at cost plus ten percent (10%), plus shipping.(7-1-25)T

vi. An invoice with the usual and customary charges of the provider, and documentation in the form of operation reports, chart notes or medical records. (7-1-25)T

v. Home- and community-based services (HCBS) are priced in accordance with approved service criteria. (7-1-25)T

03. Services Normally Billed Directly to the Patient. If a provider bills services directly to patients, the provider must submit a claim form to the Department for reimbursement. (7-1-25)T

04. Other Noninstitutional Services. The Department will reimburse for noninstitutional services unless otherwise specified. (7-1-25)T

05. Cost Reporting. Providers subject to filing a Medicaid cost report must use the Department designated reporting forms, unless the Department approves an exception. Requests to use alternate forms must be sent to the Department in writing, with samples attached, ninety (90) days prior to the report due date. Requests are not a reason for late filing. (7-1-25)T

06. For Providers Subject to Retrospective Cost Settlement. Following receipt of a finalized Medicare cost report and timely receipt of other requested information to fairly cost settle with a provider, the Department sends a certified letter with return receipt requested to the provider setting forth the underpayment or overpayment amounts made to the provider. The notice of results of a final retroactive adjustment are sent even when

a provider intends to appeal or has appealed the Medicare Intermediary's determination of cost settlement. When the determination shows that a provider owes Medicaid because total interim and other payments exceeded cost limits, the state takes the necessary action to recover overpayments, including suspending interim payments sixty (60) days after the provider receives the notice. Recovery or suspension actions continue even after the state receives a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments are made to the settlement amount. (7-1-25)T

a. The Department makes every effort to issue a notice of program reimbursement within twelve (12) months of receiving a cost report. (7-1-25)T

b. A Medicaid completed cost settlement may be reopened by a provider or the state within a three (3) year period from the date of the notice of program reimbursement. The issues must have been raised, appealed, and resolved by reopening the Medicare Intermediary's cost report. Issues previously addressed and resolved by the state's appeal process are not cause to reopen a finalized cost settlement. (7-1-25)T

07. Procedures for Medicare Cross-Over Claims. (7-1-25)T

a. If a Medicaid participant is eligible for Medicare, the provider must first bill Medicare for the services before billing the Department. (7-1-25)T

b. If a provider accepts a Medicare assignment, the Department will forward payment to the provider automatically based upon the Medicare Summary Notice (MSN) that is received from the Medicare Part B Carrier. (7-1-25)T

c. If a provider does not accept a Medicare assignment, an MSN must be submitted with a claim to the Department. (7-1-25)T

d. For all other services, an MSN must be submitted to the Department with a claim. (7-1-25)T

e. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (7-1-25)T

08. Appeals Process. Reimbursement for services originally denied by the Department will be made if such decision is reversed by the appeals process. (7-1-25)T

031. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS.
This section of rule applies only to providers that are retrospectively cost settled. (7-1-25)T

01. Interest Charges. Medicaid charges interest on overpayments, and pays interest on underpayments, as follows: (7-1-25)T

a. If full repayment from an indebted party is not received within sixty (60) days after the provider received the Department reimbursement notice, interest accrues from the receipt date and is charged on any unpaid settlement balance for each thirty (30)-day period of delayed payment. Periods of less than thirty (30) days are treated as a full thirty (30)-day period, and the full interest charge is applied to any unpaid balance. Each payment is applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not allowable interest expenses. (7-1-25)T

b. When the Department determines an overpayment exists, it may waive interest charges if the administrative costs to collect exceeds the charges. (7-1-25)T

c. The interest rate on overpayments and underpayments is compounded monthly. (7-1-25)T

d. Balance and interest are retroactively adjusted to equal the amounts that would have been due based on any changes that occurred due to results of a final determination in an administrative or judicial appeals process. Interest penalties only apply to unpaid amounts and are subordinated to final interest determinations made in a judicial review process. (7-1-25)T

02. Recovery Methods. One (1) of the following will be used for recovery of overpayments: (7-1-25)T

a. Upon receiving a notice of program reimbursement, a provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. (7-1-25)T

b. The provider may: (7-1-25)T

i. Request in writing to make overpayment recovery over a period of twelve (12) months or less; and (7-1-25)T

ii. Submit documentation demonstrating that their financial integrity would be irreparably compromised if repayments occurred over a shorter time period. (7-1-25)T

c. If a provider does not respond to the program reimbursement notice within thirty (30) days of receipt, the Department initiates recovery of the entire unpaid balance in addition to accrued interest. (7-1-25)T

032. – 034. (RESERVED)

035. RECORDS.
Providers must maintain records in sufficient detail to allow the Department to audit for compliance, medical necessity, quality assurance, and determination of payment methodology. The Department, the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review pertinent records of providers and related entities receiving Medicaid reimbursement. These reviews may be conducted for audit purposes outside of processes in IDAPA 16.05.07. (7-1-25)T

01. Provider Refusal. Refusal of a provider to permit the Department to review records pertinent to Medicaid will constitute grounds for: (7-1-25)T

a. Withholding payments until access to the requested information is granted; (7-1-25)T

b. Recoupment of payments; or (7-1-25)T

c. Suspending the provider. (7-1-25)T

02. Undocumented Services. Undocumented services are subject to recoupment. (7-1-25)T

03. Availability of Records. Records must be available for audit, with or without prior notice, during any working day and regular business hours at the provider's principal place of business. (7-1-25)T

04. Retention of Records. Providers will retain records required under this rule for a period of five (5) years from the date of final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to pay for services. (7-1-25)T

036. – 039. (RESERVED)

GENERAL REIMBURSEMENT PROVISIONS FOR INSTITUTIONAL PROVIDERS (Sections 040-049)

040. DOCUMENTATION FOR AUDITS.

01. Expenditure Documentation. Must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting an expenditure. (7-1-25)T

02. Cost Allocation Process. Include depreciation or amortization of assets and indirect expenses allocated to activities or functions based on the original identity of the costs. Documentation to support basis for

allocation must be available for verification. The assets referred to in this Section of rule are economic resources of the provider recognized and measured in conformity with GAAP. (7-1-25)T

03. Revenue Documentation. Must include the amount, date, purpose, and source of revenue. (7-1-25)T

04. Additional Documentation. (7-1-25)T

a. Providers are given an opportunity to provide documentation before an interim final audit report is issued. (7-1-25)T

b. Providers are not allowed to submit additional documentation in support of cost items after issuance of the interim final audit report. (7-1-25)T

041. – 044. (RESERVED)

045. RELATED PARTY TRANSACTIONS.

01. Principle. Allowability of costs applicable to services, facilities, and supplies furnished by entities related to the provider is subject to the regulations in 42 CFR 413.17, et al., and PRM. (7-1-25)T

02. Determination of Common Ownership or Control. A provider organization is related to a supplying organization as defined under 42 CFR 413.17. If the elements of common ownership or control are not present in both organizations, the organizations are deemed unrelated. (7-1-25)T

03. Cost to Related Organizations. The charges to a provider from related organizations may not exceed the billing to the related organization for these services. (7-1-25)T

04. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowed. (7-1-25)T

05. Interest Expense. Interest expense on loans between related entities is not reimbursable under Chapters 2, 10, and 12, PRM. (7-1-25)T

06. Exception. An exception to the general principle applicable to related organizations applies if the provider demonstrates they meet the requirements in 42 CFR 413.17(d). The exception is not applicable to sales, lease or rentals of hospitals, which do not meet the requirement that there be an open, competitive market for the facilities furnished under the PRM. (7-1-25)T

a. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (7-1-25)T

b. When a facility is purchased from a related entity, the purchaser's depreciable basis must not exceed the seller's net book value under the PRM. (7-1-25)T

046. (RESERVED)

047. LONG-TERM CARE FACILITY PAYMENT.
Long-term care facilities are reimbursed the lower of their customary charges, their actual reasonable costs, adjusted by a BAF for NFs, or the standard costs for their class as set forth under the PRM. Upper payment limits must not exceed payments determined as reasonable costs under Medicare standards and principles. (7-1-25)T

048. – 049. (RESERVED)

SPECIFIC PROVIDER REIMBURSEMENT
(Sections 050-059)

050. NF AND ICF/IID REIMBURSEMENT.

01. Reasonable Cost Principles. To be allowable, costs must be reasonable, ordinary, necessary, and related to patient care. Providers are expected to incur costs in such a manner that economical and efficient delivery of quality health care to participants results. (7-1-25)T

02. Application of Reasonable Cost Principles. Reasonable costs of any services are determined under this rule and the PRM, as modified by exceptions contained herein, and used to identify cost items included on Idaho's Uniform Cost Report. (7-1-25)T

a. Reasonable costs account for both direct and indirect costs of provider services, including normal standby costs. (7-1-25)T

b. Costs may vary from one (1) facility to another due to a variety of factors. Medicaid intends to reimburse providers for the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed under provisions of Title 56, Idaho Code, or unallowable by application of promulgated regulation. (7-1-25)T

c. The expectation of reasonable actual operating costs is that providers seek to minimize costs and that actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (7-1-25)T

d. The Department does not pay for costs determined to exceed a level that buyers incur in the absence of clear evidence that higher costs were unavoidable. (7-1-25)T

e. Form and substance of transactions prevails over the form. Financial transactions are disallowed to the extent that the substance of a transaction fails to meet reasonable cost principles or comply with rules and policy. (7-1-25)T

03. Home Office Cost Principles. Reasonable cost principles extend to home office costs allocated to individual providers. In addition, the home office, through a provider, provides documentation on the basis used to allocate costs among the various entities it administers or directs. (7-1-25)T

04. Application of Related Party Transactions. (7-1-25)T

a. Charges to a provider from related organizations may not exceed the billing to a related organization for these services. (7-1-25)T

b. All home office costs unrelated to patient care are not allowable. (7-1-25)T

05. Compensation to Relatives. Payment for relatives of owners or administrators is allowed only for actual services performed, when necessary, adequately documented, and reasonable. (7-1-25)T

a. Compensation billed to the Department must be included in compensation reported for tax purposes and actually paid. (7-1-25)T

i. When services are performed without pay, no cost may be reported. (7-1-25)T

ii. Time records documenting actual hours worked are required for compensation to allow for reimbursement. (7-1-25)T

iii. Compensation for undocumented work hours is not reimbursable. (7-1-25)T

b. Related persons are defined as these relationships with a provider: (7-1-25)T

i. Spouse; (7-1-25)T

ii. Child or a descendant of a child; (7-1-25)T

iii. Siblings, stepsiblings, or descendant thereof; (7-1-25)T

iv. Parent, stepparent, siblings thereof, and their ancestors; (7-1-25)T

v. Related by marriage; (7-1-25)T

vi. Any other person without an arm's length relationship. (7-1-25)T

06. Idaho Owner-Administrator Compensation. Allowable compensation to owners and related persons providing any administrative services is limited based on the schedule in this section. (7-1-25)T

a. The following schedule is used to determine the maximum amount of owner administrative compensation. This schedule shows the limits set for 2024 and will be adjusted annually based upon changes in average hourly earnings in nursing and personal care facilities as published by a nationally recognized forecasting firm. (7-1-25)T

Licensed Bed Range	Upper limit
51 - 100	$161,303
101 - 150	$177,424
151 - 250	$240,940
251 - up	$345,861

(7-1-25)T

b. Maximum allowable compensation for owners providing administrative services is determined by adjusting the schedule as follows: (7-1-25)T

i. To determine the number of beds applicable on the schedule, all licensed beds in any facility an owner provides administrative services to is counted, regardless of whether they are in the same facility. (7-1-25)T

ii. For owners providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds determines the upper limit for allowable compensation. (7-1-25)T

iii. For owners providing services to less than fifty-one (51) beds, administrative related duties are reimbursed at the hourly rate allowable if an owner provided services to fifty-one (51) beds. Services other than administrative services performed by the owner are allowable at the reasonable market rate. To be allowable, hours for each service type is documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner managing fifty (50) licensed beds or less exceed the limit applicable for an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds. (7-1-25)T

c. Compensation for persons related to an owner is evaluated in the same manner as for an owner. (7-1-25)T

d. When an owner provides services to more than one facility, compensation is distributed on the same basis as costs allocated for non-owners. (7-1-25)T

e. For more than one (1) owner or related party to receive compensation, services must be actually

performed, documented, and necessary. Total compensation must be reasonable, and no greater than an amount for which the same services could be obtained on the open market. Standard full-time compensation is measured as two thousand eighty (2,080) hours. Compensation of an owner or relative of an owner will not exceed the compensation determined from the Administrative Compensation Schedule, and, when paid on an hourly basis, will not exceed compensation determined by the Administrative Compensation Schedule divided by two thousand eighty (2,080.) (7-1-25)T

07. Filing Dates. (7-1-25)T

a. Deadlines for annual cost reports are the last day of the third month following a fiscal year end or the deadline imposed by Medicare for providers required to file Medicare cost reports. (7-1-25)T

b. Waivers to delay filing by thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for waivers and reasons must be submitted prior to the deadline. A written decision is rendered within ten (10) days. (7-1-25)T

08. Failure to File. Late reports result in reductions to the interim rate. Failure to file required cost reports, including required supplemental information, unless a waiver is granted, results in a reduction of ten percent (10%) of the provider's rate(s) the first day of the month following a deadline date. Continued failure to comply results in complete payment suspension on the first day of the following month. When suspension or reduction occurs and a provider filed the required cost reports, amounts accruing to the provider during a suspension or reduction period are restored. Loss of license or certification results in immediate termination of reimbursement, full scope audit, and settlement for the cost period. (7-1-25)T

09. Accounting System. Providers must file reports using the accrual basis and conform with GAAP or within provisions of the specified guidelines. Recorded transactions must be capable of verification by Departmental audit. (7-1-25)T

10. Audits. (7-1-25)T

a. All financial reports are subject to audit to: (7-1-25)T

i. Determine that transactions recorded in the books of record are substantially accurate and reliable as a basis to determine reasonable costs. (7-1-25)T

ii. Determine that facility internal controls are sufficiently reliable to disclose the results of a provider's operations. (7-1-25)T

iii. Determine that Medicaid participants received the required care based on economy and efficiency. (7-1-25)T

iv. Determine that GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (7-1-25)T

v. Ensure policies and practices sufficiently meet fiduciary responsibilities for patients, funds, and property. (7-1-25)T

vi. Effect final settlement when required. (7-1-25)T

b. Normally, all annual statements are audited within the following year. (7-1-25)T

c. Other statements and some annual audit recommendations are subject to limited scope audits evaluating provider compliance. (7-1-25)T

d. Additional audits are required for: (7-1-25)T

i. Significant changes of ownership. (7-1-25)T

ii. Changes in management. (7-1-25)T

iii. When an overpayment of twenty-five percent (25%) or more resulted in a completed cost period. (7-1-25)T

e. Annual field audits are by appointment. Auditors identify themselves with a letter of authorization or Department I.D. cards. (7-1-25)T

11. Audit Standards and Requirements. (7-1-25)T

a. Before making any program payments to a prospective provider, the intermediary reviews a provider's accounting system and its capability of generating accurate statistical cost data. When a provider's record keeping capability fails to meet program requirements, the intermediary offers limited consultative services or suggests revisions of a provider's system to enable compliance. (7-1-25)T

b. Examination of records and documents includes: (7-1-25)T

i. Corporate charters or other ownership documents including those for parent or related companies and attachments describing property. (7-1-25)T

ii. Minutes and memos of governing bodies, including committees and its agents. (7-1-25)T

iii. All contracts. (7-1-25)T

iv. Tax returns and records, including workpapers and other supporting documentation. (7-1-25)T

v. All insurance contracts and policies including riders and attachments. (7-1-25)T

vi. Leases. (7-1-25)T

vii. Fixed asset records (see Capitalization of Assets). (7-1-25)T

viii. Schedules of patient charges. (7-1-25)T

ix. Notes, bonds, and other evidence of liabilities. (7-1-25)T

x. Capital expenditure records. (7-1-25)T

xi. Bank statements, canceled checks, deposit slips, and bank reconciliations. (7-1-25)T

xii. Evidence of litigations involving a facility or its owners. (7-1-25)T

xiii. All invoices, statements, and claims. (7-1-25)T

xiv. Financial audit work papers prepared by any accounting firm a provider engages with are considered the provider’s property and must be available to the intermediary upon request, under PRM, Subparagraph 2404.4(Q). (7-1-25)T

xv. Ledgers, journals, all working papers, subsidiary ledgers, records, and documents relating to financial operation. (7-1-25)T

xvi. All patient records, including trust funds and property. (7-1-25)T

xvii. Time studies and other cost determining information. (7-1-25)T

xviii. All other sources of information needed to form an audit opinion. (7-1-25)T

c. Adequate cost information developed by a provider must be current, accurate, and sufficient detail to support payments made for services rendered. This includes all ledgers, books, records, and original cost evidence including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, timecards, payrolls, bases for apportioning costs, and other documentation pertaining to determination of reasonable cost, capable of being audited under PRM, Section 2304. (7-1-25)T

d. Adequate expense documentation includes invoices or statements with invoices attached supporting the statement and must include: (7-1-25)T

i. Service or sale date; (7-1-25)T

ii. Terms and discounts; (7-1-25)T

iii. Quantity; (7-1-25)T

iv. Price; (7-1-25)T

v. Vendor name and address; (7-1-25)T

vi. Delivery address if applicable; (7-1-25)T

vii. Contract or agreement references; and (7-1-25)T

viii. Description including quantities, sizes, specifications, and brand names of services performed. (7-1-25)T

e. Minor movable equipment is not capitalized. The cost of fixed assets and major movable equipment is capitalized and depreciated over the estimated useful life of an asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (7-1-25)T

f. Completed depreciation records must include the following for each asset: (7-1-25)T

i. Description of the asset including serial number, make, model, accessories, and location. (7-1-25)T

ii. Cost basis supported by invoices for purchase, installation, etc. (7-1-25)T

iii. Estimated useful life. (7-1-25)T

iv. Depreciation method (straight line, double declining balance, etc.). (7-1-25)T

v. Salvage value. (7-1-25)T

vi. Method of recording depreciation consistent with GAAP. (7-1-25)T

vii. Additional information, such as additional first year depreciation, even when not an allowable expense. (7-1-25)T

viii. Reported depreciation expense for the year and accumulated depreciation tied to the asset ledger. (7-1-25)T

g. Depreciation methods are always acceptable. Methods of accelerated depreciation are only acceptable upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (7-1-25)T

h. An asset's depreciable life may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, Guidelines. Deviation from these guidelines is allowable

only upon Department authorization. (7-1-25)T

i. Lease purchase agreements are generally recognized by any the following characteristics: (7-1-25)T

i. Lessee assumes normal ownership costs, such as taxes, maintenance, etc.; (7-1-25)T

ii. Intent to create security interest; (7-1-25)T

iii. Lessee acquires title by exercising a purchase option that requires little or no additional payment or, additional payments substantially less than the fair market value at purchase date; (7-1-25)T

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (7-1-25)T

v. Initial loan term significantly less than the useful life and lessee has the option to renew at a rental price substantially less than fair rental value. (7-1-25)T

j. Assets acquired under such agreements are viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes, and maintenance are allowable. Rental or lease payments are not reimbursable. (7-1-25)T

k. Complete personnel records including: (7-1-25)T

i. Employment applications. (7-1-25)T

ii. W-4 Forms. (7-1-25)T

iii. Authorizations for any deductions such as insurance, credit union, etc. (7-1-25)T

iv. Routine evaluations. (7-1-25)T

v. Pay raise authorizations. (7-1-25)T

vi. Statements of understanding of policies, procedures, etc. (7-1-25)T

vii. Fidelity bond applications (when applicable). (7-1-25)T

l. A system of internal control intended to provide a method of handling all routine and nonroutine tasks related to: (7-1-25)T

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (7-1-25)T

ii. Promoting accuracy and reliability in financial records. (7-1-25)T

iii. Encouraging and measuring compliance with company policy and legal requirements. (7-1-25)T

iv. Determining the degree of efficiency related to various aspects of operations. (7-1-25)T

m. An adequate system of internal control over cash disbursements including: (7-1-25)T

i. Payment on invoices only, or statements supported by invoices. (7-1-25)T

ii. Authorizations for purchase; a purchase order. (7-1-25)T

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (7-1-25)T

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (7-1-25)T

v. Check of invoice accuracy. (7-1-25)T

vi. Invoice approval policy. (7-1-25)T

vii. Method of invoice cancellation to prevent duplicating payment. (7-1-25)T

viii. Adequate separation of duties between ordering, recording, and paying. (7-1-25)T

ix. System separation of duties between ordering, recording, and paying. (7-1-25)T

x. Signature policy. (7-1-25)T

xi. Pre-numbered checks. (7-1-25)T

xii. Statement of policy regarding cash or check expenditures. (7-1-25)T

xiii. Adequate internal control over recording transactions in the books of record. (7-1-25)T

xiv. An imprest system for petty cash. (7-1-25)T

n. Sound accounting practices including: (7-1-25)T

i. Documentation of accounting policies and procedures, including capitalization, depreciation, and expenditure classification criteria. (7-1-25)T

ii. Chart of accounts. (7-1-25)T

iii. Budget or operating plans. (7-1-25)T

12. Patient Funds. The safekeeping of Medicaid patient funds is the responsibility of the provider. Administration of these funds requires scrupulous care when recording all patient transactions. (7-1-25)T

a. Funds provided for a patient's personal needs are used at the patient's discretion. Providers agree to manage these funds and render an accounting of funds but may not use them in any way. (7-1-25)T

b. Providers are subject to legal and financial liabilities for committing any of the following acts and any other acts contrary to federal regulations: (7-1-25)T

i. Management fees are not charged to manage patient trust funds and constitute double payment as normally performed by a facility employee whose salary is included in reasonable cost reimbursement. (7-1-25)T

ii. Nothing is to be deducted from these funds, unless deductions are authorized by the patient or their agent in writing. (7-1-25)T

iii. Interest accruing to patient funds on deposit is the patient's property and part of their personal funds. Interest from these funds is not available to the provider for any use, including patient benefits. (7-1-25)T

c. Fund Management. Proper management includes the following at a minimum: (7-1-25)T

i. Savings accounts, maintained separately from facility funds. (7-1-25)T

ii. An accurate system of supporting receipts and disbursements to patients. (7-1-25)T

iii. Written authorization for all deductions. (7-1-25)T

iv. Signature verification. (7-1-25)T

v. Deposit of all receipts on the same day received. (7-1-25)T

vi. Minimal funds kept in a facility. (7-1-25)T

vii. All funds must always be locked. (7-1-25)T

viii. Policy statement regarding patient's funds and property. (7-1-25)T

ix. Periodic review of all policies with staff in training sessions and with all new employees upon employment. (7-1-25)T

x. System of periodic review and correction of policies and financial records for patient property and funds. (7-1-25)T

13. Legal Consultant Fees and Litigation Costs. When these costs are incurred by a provider, they are handled as follows: (7-1-25)T

a. Legal consultant fees unrelated to preparation for or appealing of a Department audit, or costs incurred by a provider in an action unrelated to litigation with the Department are allowed as part of total per diem costs the Medicaid Program reimburses according to the percentage of Medicaid patient days. (7-1-25)T

b. Costs of the provider's legal counsel when appealing findings of a Department audit are reimbursed by Medicaid only to the extent a provider prevails on the issues involved. Determination of the extent a provider prevails is based on the ratio of the total dollars at issue for an audit period under appeal to the total dollars ultimately awarded to a provider for that audit period. (7-1-25)T

c. All other litigation costs incurred by a provider for actions against the Department are not directly or indirectly reimbursable by Medicaid, unless court ordered. (7-1-25)T

051. PCS AND AGED AND DISABLED WAIVER SERVICE COST SURVEYS.
The Department conducts cost surveys for one hundred percent (100%) of providers, customized for each of the services identified in this rule. Providers who refuse or fail to respond to state surveys may be disenrolled. The Department derives rates using direct care staff costs, employment related expenditures (ERE), program related costs, and indirect general and administrative costs in payment methodology, when these costs are incurred by a provider. (7-1-25)T

01. Wage Rates. Reimbursement methodology used when an expenditure is incurred by the provider type. Wages are identified on the Bureau of Labor Statistics (BLS) website at www.bls.gov when there is a comparable occupation title for direct care staff. When no comparable occupation title for direct care staff exists, then a weighted average hourly rate (WAHR) methodology is used. (7-1-25)T

02. ERE. (7-1-25)T

a. The BLS report at www.bls.gov for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions are used to determine the incurred ERE by each provider type. (7-1-25)T

b. The Internal Revenue Service employer cost for social security and Medicare benefits at www.irs.gov is used to determine the incurred ERE by provider type. (7-1-25)T

03. Expenditures by Provider Type. Cost surveys are used to collect indirect general, administrative, and program related costs. Costs are ranked by costs per provider, and the Medicaid cost used in the rate methodology is established at the 75th percentile. (7-1-25)T

052. SPECIALIZED REIMBURSEMENT: CERTAIN HCBS AND CHIS.

01. Applicable HCBS and CHIS Programs. The following HCBS provider types and CHIS are reimbursed as described in this section: (7-1-25)T

a. Developmental Disability Agencies (DDA) providing services to adults or children; (7-1-25)T

b. Residential Habilitation Agencies; (7-1-25)T

c. Supported Employment Agencies; (7-1-25)T

d. Service Coordination Agencies; and (7-1-25)T

e. CHIS. ()

02. Timing, Description, and Rate Review Results. (7-1-25)T

a. The Department conducts a cost survey and reviews rates at least once every five (5) years for each provider type specified in this rule. Cost surveys are conducted in the order and on a schedule established by the Department. (7-1-25)T

b. The Department prepares an annual trigger analysis and publishes the report on the Medicaid Providers webpage. This annual report describes the triggers for interim rate reviews, a summary of data reviewed for each trigger, and the Department's determination and rationale of whether each trigger was met. The Department conducts interim rate reviews when one (1) or more of the following triggers occur: (7-1-25)T

i. Substantiated participant complaints, critical incidents, or both, related to a lack of qualified providers indicate emerging access issues; (7-1-25)T

ii. Department quality reports or substantiated participant complaints and critical incidents related to the quality of services indicate emerging quality issues; or (7-1-25)T

iii. Federal or Idaho minimum wage requirements in effect at the time of a standard rate review significantly change. (7-1-25)T

03. Cost Survey Procedures. The Department conducts periodic cost surveys. Providers who refuse or fail to respond may be disenrolled as a Medicaid provider. (7-1-25)T

04. Rate Setting Methodology. Providers must demonstrate that the average percent of wage and benefits paid to direct care staff (or service coordinators) meets or exceeds the percent of wages and ERE used to establish the rates for a service type. The cost components and new rates are established in accordance with the following components: (7-1-25)T

a. Direct Care Staff and Service Coordinator wages paid to agency employees or contractors who perform duties described in the applicable service description for at least seventy-five percent (75%) of the total annual amount of time compensated. (7-1-25)T

i. The wage component used to establish the new rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current BLS State Occupational Employment and Wage Estimates table for Idaho that most closely aligns with the duties, education, and supervision requirements for staff providing the service is used. If more than one (1) occupation profile aligns, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is used. (7-1-25)T

ii. When no comparable occupation profile exists, then the wage component to establish the new rate is set using the WAHR of surveyed wages included in the final cost survey results. (7-1-25)T

iii. The Department makes the final determination of BLS occupation profiles. (7-1-25)T

iv. The Department evaluates an appropriate wage inflation factor based on economic data available at the time the rate is set. (7-1-25)T

b. ERE are expenses incurred by an agency to benefit direct care staff or service coordinators in these categories: paid leave, supplemental pay, payroll taxes, workers' compensation, insurance coverage, and retirement contributions. The ERE component percentage (ERE%) to establish a new rate is set using the cumulative percentage of employer costs for compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15. (7-1-25)T

c. Program-Related Expenses (PRE) are wages and other expenses supporting the objectives and provision of a service but not tied to any individual receiving a service. Regulatory requirements related to service delivery are PRE. (7-1-25)T

i. Program-related staff are agency employees who perform duties as required by statute or rule for at least seventy-five percent (75%) of the total annual amount of time compensated. (7-1-25)T

ii. Using data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by their total wages. Each agency's PRE% is ranked and the mean of the PRE% rank is used to calculate a new rate. (7-1-25)T

d. General and Administrative (G&A) Expenses are wages and other expenses related to daily operations common across all businesses. (7-1-25)T

i. G&A staff are agency employees who perform administrative duties for at least seventy-five percent (75%) of the total annual amount of time compensated. (7-1-25)T

ii. Using data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus total ERE, total PRE, and total G&A expenses. Each agency's G&A% is ranked and the mean of the G&A% rank is used to calculate a new rate. (7-1-25)T

iii. The G&A% used to calculate a new rate will not exceed ten percent (10%) of the total rate per staff hour. (7-1-25)T

e. Total Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) / (1-(G&A%)). (7-1-25)T

f. The Department is not obligated to make budget requests based on the total rate per staff hour and takes into consideration factors of efficiency, economy, quality of care, and access to care when determining rates. Rates may be set at a percentage of the total rate per staff hour and are subject to approval by the Idaho Legislature. (7-1-25)T

g. The reimbursement rates calculated for CHIS include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location. ()

05. Quality Incentives. Based on the quality of services provided, a provider may be eligible for incentive payments. (7-1-25)T

a. Quality measures and associated payment percentages are established by the Department, in collaboration with the state's protection and advocacy organization designated by the Governor and described in the Idaho Medicaid Provider Handbook. The Department provides sixty (60) days prior notice of any substantive changes to quality measures and associated payment percentages. (7-1-25)T

b. Incentive payments are subject to availability of State and federal funds and may be rescinded if service quality declines. (7-1-25)T

053. ACCOUNTING TREATMENT.
GAAP, concepts, and definitions are used unless otherwise specified. When alternative treatments are available under GAAP, the acceptable treatment is the one that most clearly attains program objectives. (7-1-25)T

01. Final Payment. Final payment is made based on the reasonable cost of services as determined by audit under these rules. (7-1-25)T

02. Overpayments. Recovery of overpayments is attempted as quickly as possible consistent with the financial integrity of the provider resulting in two (2) circumstances: (7-1-25)T

a. For unfiled cost reports, all payments included in the recovery period and any subsequent payments are due. (7-1-25)T

b. Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the periods in question. When such a determination is made, the interim reimbursement rate (IRR) is reduced. This reduction is designated to discontinue overpayments (on an interim basis) or recover overpayments. (7-1-25)T

054. SPECIALIZED REIMBURSEMENT: ELECTRONIC VISIT VERIFICATION (EVV).

01. Services Requiring EVV. (7-1-25)T

a. Home Health. (7-1-25)T

b. State Plan PCS. (7-1-25)T

c. Attendant Care, Homemaker and Respite under the A&D Waiver. (7-1-25)T

02. EVV Requirements. Providers must: (7-1-25)T

a. Select and maintain an EVV system and certified as compliant with the Department's MMIS aggregator; (7-1-25)T

b. Retain documented participant consent for the provider's EVV methods; (7-1-25)T

c. Develop and maintain policies and procedures for use of EVV technology, including strategies for safeguarding participant data and privacy; and (7-1-25)T

d. Submit EVV data capturing six (6) system-validated data elements for services rendered: (7-1-25)T

i. Service date; (7-1-25)T

ii. Service start and end times; (7-1-25)T

iii. Direct service provider; (7-1-25)T

iv. Recipient of service; (7-1-25)T

v. Billable service; and (7-1-25)T

vi. Service delivery location. (7-1-25)T

e. Submit EVV data to the State's aggregator prior to billing claims. (7-1-25)T

055. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations if a provider demonstrates by convincing evidence to the satisfaction of an intermediary: (7-1-25)T

01. Supplying Organization. Is a bona fide separate organization; (7-1-25)T

02. Non-Exclusive Relationship. A substantial part of the supplying organization's business activity type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control in an open, competitive market. (7-1-25)T

03. Sales and Rental of Extended Care Facilities. The exception is not applicable to sales, leases, or rentals of NFs or extended care facilities and do not meet the requirement that there be an open, competitive market for the facilities furnished. (7-1-25)T

a. Rental expense for transactions between related entities is not recognized. Costs of ownership are allowed. (7-1-25)T

b. When a facility is purchased from a related entity, the purchaser's depreciable basis will not exceed the seller's net book value. (7-1-25)T

056. – 059. (RESERVED)

EXCLUDED SERVICES
(Sections 060-069)

060. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAID.

01. Service Categories Not Covered. The following service categories are not covered for payment by Medicaid: (7-1-25)T

a. Acupuncture services; (7-1-25)T

b. Naturopathic services; (7-1-25)T

c. Bio-feedback therapy; (7-1-25)T

d. Group hydrotherapy; (7-1-25)T

e. Fertility-related services, including testing; (7-1-25)T

f. Vocational services except for supported employment services; (7-1-25)T

g. Educational services; (7-1-25)T

h. Recreational services; (7-1-25)T

i. Duplicative services; (7-1-25)T

j. Housing except when approved for a medical institution; and (7-1-25)T

k. Food, except when medically necessary or the home-delivered meals benefit. (7-1-25)T

02. Types of Treatments and Procedures Not Covered. The costs of provider and hospital services for the following types of treatments and procedures are not covered for payment by Medicaid: (7-1-25)T

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; (7-1-25)T

b. Services for convenience, comfort, or cosmetic reasons except when allowed elsewhere in rule. Hospice services, and reconstructive surgery that has prior approval by the Department are covered benefits;

(7-1-25)T

c. Laetrile therapy; (7-1-25)T

d. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program or major commercial carriers; (7-1-25)T

e. Drugs supplied to patients for self-administration other than those allowed under these rules; (7-1-25)T

f. The treatment of complications, consequences, or repair of any medical procedure where the original procedure was not covered by Medicaid, unless the resultant condition is life-threatening as determined by the Department; (7-1-25)T

g. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; (7-1-25)T

h. Surgical procedures on the cornea for myopia; or (7-1-25)T

i. Services as detailed in Section 56-273, Idaho Code. (7-1-25)T

03. Experimental Treatments or Procedures. Experimental treatments and procedures, and the costs for all follow-up medical treatment directly associated with such a procedure are not covered. Treatments and procedures are deemed experimental under the following circumstances: (7-1-25)T

a. The treatment or procedure is in Phase I clinical trials; (7-1-25)T

b. There is inadequate available clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or (7-1-25)T

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (7-1-25)T

061. INVESTIGATIONAL PROCEDURES OR TREATMENTS.
The Department may cover investigational procedures or treatments on a case-by-case basis for life-threatening conditions when no other treatment options are available. For these cases, a focused case review is completed by the Department. The Department will determine coverage based on this review. (7-1-25)T

01. Focused Case Review. A focused case review consists of assessment of: (7-1-25)T

a. Health benefit to the participant; (7-1-25)T

b. Risk to the participant; (7-1-25)T

c. Standard treatment for the participant's condition, including alternative treatments; (7-1-25)T

d. Specific inclusion or exclusion by Medicare national coverage guidelines; (7-1-25)T

e. Phase of the clinical trial of the proposed procedure or treatment; (7-1-25)T

f. Guidance regarding the proposed procedure or treatment by national organizations; (7-1-25)T

g. Pertinent clinical data and peer-reviewed literature; and (7-1-25)T

h. Ethics Committee review, if appropriate. (7-1-25)T

02. Additional Clinical Information. If there is insufficient information from the focused case review to render a coverage decision, the Department may seek an independent professional opinion. (7-1-25)T

062. – 069. (RESERVED)

MEDICAID BASIC PLAN COVERED SERVICES
(Sections 070-449)

SUB AREA: HOSPITAL SERVICES
(Sections 070-089)

070. HOSPITAL SERVICES: DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is covered for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for NF level of care, or in-home services that are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (7-1-25)T

02. All-Patient Refined Diagnosis Related Group (APR-DRG). A payment methodology outlined in the Medicaid Provider Agreement. (7-1-25)T

03. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement if cost settlements are applicable or determined using the version of the cost report used for prospective payment system (PPS) rate setting, consist of those costs permitted by the principles of reimbursement contained in the PRM and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. (7-1-25)T

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. (7-1-25)T

05. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. (7-1-25)T

06. Critical Access Hospitals (CAH). A rural hospital as set forth in 42 CFR Section 485.620. (7-1-25)T

07. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. (7-1-25)T

08. Inpatient Customary Hospital Charges. Customary inpatient hospital charges reflect the regular rates for inpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. (7-1-25)T

a. All in-state providers not described in b. through d. below will be paid a final prospective payment rate using the APR-DRG classification system as described in these rules. (7-1-25)T

b. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost using a retrospective cost settlement upon receipt of a final Medicare cost report. (7-1-25)T

c. In-state and those out-of-state within thirty-five (35) miles of the Idaho border, CAHs will be reimbursed at one hundred one percent (101%) of allowable cost using a retrospective cost settlement upon receipt of a final Medicare cost report. (7-1-25)T

d. All out-of-state providers not described in a. through c. above will be paid a final prospective

payment rate with no retrospective cost settlement using the APR-DRG classification system as described in these rules. The out-of-state APR-DRG rates were developed to provide a combined cost coverage of eighty-seven percent (87%) when all out-of-state providers are averaged together in keeping with Section 56-265(6)(b), Idaho Code. (7-1-25)T

09. Outpatient Services Customary Hospital Charges. Customary outpatient hospital charges reflect the regular rates for outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services be related to the cost of services billed to the Department. (7-1-25)T

a. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost. (7-1-25)T

b. In-state and those out-of-state within thirty-five (35) miles of the Idaho border, CAHs will be reimbursed at one hundred one percent (101%) of allowable cost. (7-1-25)T

c. All hospitals that are not described in a. through b. above will be subject to the outpatient reimbursement parameters outlined in the Medicaid Provider Agreement and Section 56-265, Idaho Code. (7-1-25)T

10. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. (7-1-25)T

11. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH payments. (7-1-25)T

12. Disproportionate Share Threshold. The disproportionate share threshold is: (7-1-25)T

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or (7-1-25)T

b. A Low-Income Revenue Rate exceeding twenty-five percent (25%). (7-1-25)T

13. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. (7-1-25)T

14. Low-Income Revenue Rate. The Low-Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: (7-1-25)T

a. Total Medicaid inpatient and outpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital in the same cost reporting period; plus (7-1-25)T

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments' county assistance programs. (7-1-25)T

15. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. (7-1-25)T

16. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. Inpatient days includes ANDs, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. (7-1-25)T

17. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low-income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. (7-1-25)T

18. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be near the hospital where it is based, and both facilities serve the same patient population (e.g., from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). (7-1-25)T

19. Reasonable Costs. Reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care that a prudent and cost-conscious hospital would pay for a given item or service. (7-1-25)T

20. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, both inpatient and outpatient costs of uninsured patients will be considered. (7-1-25)T

21. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. (7-1-25)T

071. INPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.
The policy, rules, and regulations to be followed are 42 CFR 456.50 through 42 CFR 456.145. (7-1-25)T

01. Initial Length of Stay. PA requirement for an initial length of stay will be established by the Department in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. (7-1-25)T

02. Extended Stay. The Department will establish authorization requirements in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. An authorization is necessary when the appropriate care of the participant indicates the need for hospital days more than the initial length of stay, or previously approved extended stay. (7-1-25)T

03. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services for hospitals not reimbursed under DRG methodologies: (7-1-25)T

a. Payment for accommodations is limited to the hospital's all-inclusive rate. The all-inclusive rate is a flat fee charge incurred daily that covers both room and board. (7-1-25)T

b. The Department will not authorize reimbursement above the all-inclusive rate unless the attending provider orders a room that is not an all-inclusive rate room because of medical necessity. (7-1-25)T

04. Diagnosis Related Group (DRG) Review and Audits. All services performed under DRG are subject to QIO reviews, retrospective reviews, and audits. The Department reserves the right to execute reviews as described in the Idaho Medicaid Provider Handbook as amended. (7-1-25)T

072. INPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Certification of Medical Necessity. At the time of admission, the physician must certify that inpatient services are necessary. Recertification must occur at least every sixty (60) days inpatient hospital services are required but may be required more frequently as determined by the Department. (7-1-25)T

02. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to a hospital and updated at least every sixty (60) days but may be required more frequently as

determined by the Department. Requirements are defined in the Idaho Medicaid Provider Handbook. (7-1-25)T

03. Request for Extended Stay. To qualify for reimbursement, authorization must be obtained from the Department. The request should be made before the initial length of stay or previously authorized extended stay ends and submitted as designated by the Department. Documentation for the request should include the most recent plan of care. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. (7-1-25)T

073. INPATIENT HOSPITAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital that provides a nursing home level of care, will be reimbursed as a NF. Hospitals not eligible for enrollment which render emergency care will be paid rates established in these rules. (7-1-25)T

074. HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.
The upper payment limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare principles of cost reimbursement. (7-1-25)T

01. Payment Procedures. The following procedures are applicable to in-patient hospitals: (7-1-25)T

a. The participant's admission and length of stay may be subject concurrent review, continued stay review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. Failure to obtain a timely QIO review as required by these rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. (7-1-25)T

b. In reimbursing hospitals, the Department will pay the lesser of customary hospital charges or Medicaid reimbursement for in-patient hospital care as set forth in this rule, unless an exception applies. The upper limits for payment must not exceed the payment that would be determined as reasonable cost using Medicare standards and principles. (7-1-25)T

02. Administratively Necessary Days (AND) Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho NFs for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. (7-1-25)T

a. The AND reimbursement rate will be calculated by the Department of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (7-1-25)T

b. Hospitals with an attached NF will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (7-1-25)T

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (7-1-25)T

03. Hospital Swing-Bed Reimbursement. The Department will pay for NF care in certain rural hospitals for participants in licensed hospital swing-beds who require NF level of care. (7-1-25)T

a. Routine services include all medical care, supplies, and services that are included in the calculation of NF property and non-property costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except prescription drugs will be reimbursed under these rules. (7-1-25)T

b. The Department will reimburse hospitals for participants under the following conditions: (7-1-25)T

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05; and (7-1-25)T

ii. The participant is authorized for payment of long-term care. (7-1-25)T

c. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (7-1-25)T

i. Payment rates for routine NF services will be at the weighted average Medicaid rate per patient day paid to hospital-based NF for routine services furnished during the previous calendar year. (7-1-25)T

ii. The rate will be calculated by the Department of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (7-1-25)T

iii. The weighted average rate for NF swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (7-1-25)T

iv. Routine services include all medical care, supplies, and services that are included in the calculation of NF property and nonproperty costs. (7-1-25)T

v. Reimbursement of ancillary services not included in the NF rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs under these rules. (7-1-25)T

04. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low-income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. (7-1-25)T

a. Mandatory Eligibility for DSH status will be provided for hospitals that: (7-1-25)T

i. Meet or exceed the disproportionate share threshold under these rules. (7-1-25)T

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (7-1-25)T

(1) This subsection does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (7-1-25)T

(2) Does not offer nonemergency inpatient obstetric services. (7-1-25)T

iii. The MUR will not be less than one percent (1%). (7-1-25)T

iv. If an Idaho hospital exceeds both disproportionate share thresholds and other mandatory eligibility is met, the payment adjustment will be the greater amount calculated using the methods of this rule except when less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals. (7-1-25)T

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-25)T

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates: ()

(1) Equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard

deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-25)T

(2) Exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-25)T

vii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding: (7-1-25)T

(1) Twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-25)T

(2) Thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-25)T

b. All hospitals in Idaho that have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days and meet the requirements unrelated to patient day utilization specified in this subsection will be designated a DSH Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (7-1-25)T

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (7-1-25)T

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (7-1-25)T

c. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (7-1-25)T

d. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (7-1-25)T

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third-party payment. (7-1-25)T

ii. Claims of uninsured costs that increase the maximum amount that a hospital may receive as a DSH payment must be documented. (7-1-25)T

e. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (7-1-25)T

f. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (7-1-25)T

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (7-1-25)T

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (7-1-25)T

iii. If based on the audit of the DSH allotment distribution, the Department determines that there was

an overpayment to a provider, the Department will immediately: (7-1-25)T

(1) Recover the overpayment from the provider; and (7-1-25)T

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (7-1-25)T

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the SSA. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (7-1-25)T

05. Out-of-State Hospitals. Hospitals will have a cost settlement computed with the state of Idaho if the following conditions are met: (7-1-25)T

a. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (7-1-25)T

b. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (7-1-25)T

06. Audit Function. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Medicare and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (7-1-25)T

07. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor timecards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (7-1-25)T

08. Interim Cost Settlements. The Department may initiate, or a hospital may request an interim cost settlement based on the Medicare cost report as submitted, for hospitals subject to cost settlement. (7-1-25)T

a. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (7-1-25)T

b. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (7-1-25)T

09. Non-Appealable Items. The formula for the determination of the hospital inflation index, the principles of reimbursement that define allowable cost, non-Medicaid program issues, interim rates that follow state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits are not acceptable as appealable items. (7-1-25)T

10. Interim Reimbursement Rates for Providers Subject to Cost Settlement. The interim reimbursement rates must be reasonable and adequate to meet the necessary costs that are incurred by economically and efficiently operated providers that provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (7-1-25)T

a. Interim rates will be adjusted at least annually based on the best information available to the Department. (7-1-25)T

b. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (7-1-25)T

c. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (7-1-25)T

075. INPATIENT HOSPITAL SERVICES: QUALITY ASSURANCE.
The designated QIO must prepare, distribute, and maintain a provider manual that is periodically updated. The manual must include the following: (7-1-25)T

01. QIO Information. The QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. (7-1-25)T

02. Department Provisions. Department-selected diagnoses and procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. (7-1-25)T

03. Approval Timeframe. A provision that the QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. (7-1-25)T

04. Method of Notice. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. (7-1-25)T

05. Procedural Information. The procedures that providers or participants will use to obtain reconsideration of a denial by the QIO prior to appeal to the Department. Such requests for reconsideration by the QIO must be made in writing to the QIO within one hundred eighty (180) days of the issuance of the "Notice of Non-Certification of Hospital Days." (7-1-25)T

076. – 079. (RESERVED)

080. OUTPATIENT HOSPITAL SERVICES: DEFINITIONS.
Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative or palliative items, and services furnished by or under the direction of a provider not in need of inpatient hospital care, unless excluded by any other provisions of this chapter. (7-1-25)T

081. (RESERVED)

082. OUTPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.

01. Services Are Provided On-Site. (7-1-25)T

02. Co-Payments. (7-1-25)T

a. When an emergency room physician determines that an emergency condition does not exist, the hospital can require the participant to pay a co-payment. (7-1-25)T

b. Services may be refused when determined an emergency condition does not exist, and the participant does not make the co-payment at the time of service. The hospital will provide notification to the participant per Section 1916A(e) of the SSA. (7-1-25)T

083. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Review Prior to Delivery. Failure to obtain a timely review from the Department prior to delivery of listed procedure and diagnosis codes in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, will result in a retrospective review. (7-1-25)T

02. Follow-Up for Emergency Room Patients. Hospitals must coordinate care of patients who have a PCP. (7-1-25)T

084. (RESERVED)

085. OUTPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.
The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. Providers subject to cost settlement, outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year-end cost settlement. Maximum payment for hospital-based ambulance services, hospital outpatient diagnostic laboratory and partial care services will be limited to the Department's fee schedule. (7-1-25)T

086. – 089. (RESERVED)

**SUB AREA: AMBULATORY SURGICAL CENTERS
(Sections 090-099)**

090. – 091. (RESERVED)

092. AMBULATORY SURGICAL CENTER SERVICES: COVERAGE AND LIMITATIONS.
Surgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. The Department may add surgical procedures to the list developed by the Medicare program if the procedures meet the criteria in 42 CFR 416.166. (7-1-25)T

093. (RESERVED)

094. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
The ASC must be surveyed as required by 42 CFR 416.25 through 416.52 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. (7-1-25)T

095. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER REIMBURSEMENT.
ASC services reimbursement is packaged for use of facilities and necessary supplies as recognized by the Medicare program under 42 CFR, Part 416.164. The Department will establish a reimbursement rate for any covered procedure not covered by Medicare. (7-1-25)T

096. – 099. (RESERVED)

**SUB AREA: CASE MANAGEMENT SERVICES
(Sections 100-109)**

100. CASE MANAGEMENT.

01. Home Visiting Services. Home visiting provides for parents of vulnerable children to receive education and support on parenting topics. (7-1-25)T

02. Community Re-entry Services. Community re-entry services provide targeted case management for eligible incarcerated participants. (7-1-25)T

101. CASE MANAGEMENT: PARTICIPANT ELIGIBILITY.

01. Home Visiting Services. Participants under five (5) years of age and pregnant women at risk for

abuse, neglect, or child welfare involvement. Additional requirements are in the Idaho Medicaid Provider Handbook. (7-1-25)T

02. Community Re-entry Services. Eligible participants are those incarcerated with an adjudicated case up to age twenty-one (21) for the general population and up to age twenty-six (26) for those formerly in foster care. (7-1-25)T

102. CASE MANAGEMENT: COVERAGE AND LIMITATIONS.

01. Home Visiting Coverage. (7-1-25)T

a. Assessment for medical, educational, social, or other service needs; (7-1-25)T

b. Development and revision of a plan to address goals; (7-1-25)T

c. Referral and related activities for necessary services; and (7-1-25)T

d. Monitoring of progress. (7-1-25)T

e. Services do not include case management integral to another covered service or that constitutes direct delivery of referred services. (7-1-25)T

02. Community Re-entry Services. Medicaid will reimburse for targeted case management services for eligible incarcerated participants thirty (30) days prior to, and thirty (30) days after, their release into the community. Services include transitioning back into the community by providing access to behavioral, educational, social, and other services. (7-1-25)T

103. (RESERVED)

104. CASE MANAGEMENT: PROVIDER QUALIFICATIONS AND DUTIES.
Home visiting services are provided by the Public Health Districts or their designee. Eligible providers are certified in an evidence-based model including either Parents as Teachers, or Nurse-Family Partnership. (7-1-25)T

105. – 109. (RESERVED)

SUB AREA: MEDICAL SERVICES
(Sections 110-119)

110. MEDICAL SERVICES.
Medical services include the treatment of medical and surgical conditions by licensed professionals subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage under these rules. (7-1-25)T

111. MEDICAL SERVICES: PARTICIPANT ELIGIBILITY.
The Department will fund abortions under circumstances where the abortion is necessary to save the life of the woman. (7-1-25)T

112. MEDICAL SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Physicals. Adult preventive physical examinations are limited to one (1) per year. (7-1-25)T

02. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (7-1-25)T

03. Reconstructive Surgery. Reconstruction or restorative procedures include procedures that restore function of the affected or related body part(s). Covered procedures include breast reconstruction after mastectomy,

or the repair of other injuries resulting from physical trauma. (7-1-25)T

04. Screening Mammograms. Screening mammograms are covered when aligned with the "A" or "B" recommendations of the United States Preventative Services Task Force. (7-1-25)T

05. Tonometry. Payment for tonometry is limited to one (1) examination or, when the examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (7-1-25)T

06. Weight Loss Surgical Procedures. Abdominoplasty or panniculectomy is covered when the surgery is prior authorized by the Department. The request for PA must include the following documentation: (7-1-25)T

a. Photographs of the front, side and underside of the abdomen; (7-1-25)T

b. Treatment of any ulceration and skin infections involving the panniculus; (7-1-25)T

c. Failure of conservative treatment, including weight loss; (7-1-25)T

d. That the panniculus severely inhibits the participant's walking; (7-1-25)T

e. That the participant is unable to wear a garment to hold the panniculus up; and (7-1-25)T

f. Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. (7-1-25)T

113. MEDICAL SERVICES: PROCEDURAL REQUIREMENTS.
Abortion procedures require a licensed physician to certify in writing that the woman may die if the fetus is carried to term. (7-1-25)T

114. MEDICAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Locum Tenens Claims and Reciprocal Billing. Locum Tenens is allowed as detailed in the Idaho Medicaid Provider Handbook. (7-1-25)T

02. Misrepresentation of Services. Any representation of a service provided by a provider other than a physician as a physician service is prohibited. (7-1-25)T

03. Weight Loss Surgical Procedures. Physicians and hospitals performing surgical procedures must meet national medical standards for weight loss surgery. (7-1-25)T

115. – 118. (RESERVED)

119. MEDICAL SERVICES: DIAGNOSTIC SCREENING CLINICS.
The Department will reimburse medical social service visits to clinics that coordinate the treatment between providers for participants which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. (7-1-25)T

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each participant and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the participant will be provided by board certified provider specialists in physical medicine, neurology and orthopedics. (7-1-25)T

02. Billings. No more than five (5) hours of medical social services may be billed each state fiscal year for which the medical social worker monitors and arranges treatments and provides medical information to providers coordinating their care. (7-1-25)T

03. Provider Qualifications. The clinic will be a separate and distinct entity from the hospital or other provider practices. (7-1-25)T

SUB AREA: OTHER PROVIDER SERVICES
(Sections 120-179)

120. CHIROPRACTIC SERVICES: DEFINITIONS.
Subluxation is partial or incomplete dislocation of the spine. (7-1-25)T

121. (RESERVED)

122. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. (7-1-25)T

123. – 130. (RESERVED)

131. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
Medical necessity for diabetes education and training are evidenced by the following: (7-1-25)T

01. Participants with Diabetes. Are eligible for a Diabetes Management Program when: (7-1-25)T

a. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or (7-1-25)T

b. Uncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or (7-1-25)T

c. Recent manifestations from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. (7-1-25)T

02. Participants with Pre-Diabetes. Are eligible for the National Diabetes Prevention Program when they meet the program's guidance. (7-1-25)T

132. DIABETES EDUCATION AND TRAINING SERVICES: COVERAGE AND LIMITATIONS.

01. Concurrent Diagnosis. Only services that are reasonable and necessary will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, exercise, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. (7-1-25)T

02. No Substitutions. Providers may not use the formally structured program, or a Certified Diabetes Care and Education Specialist (CDCES), as a substitute for basic diabetic care and instruction, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. (7-1-25)T

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (7-1-25)T

133. DIABETES EDUCATION AND TRAINING SERVICES: PROCEDURAL REQUIREMENTS.
To receive diabetes counseling, the participant must have a written order and referral. (7-1-25)T

134. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Diabetes Management Program. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association or Association of Diabetes Care and Education Specialists by a CDCES, dietitian, or pharmacist. (7-1-25)T

02. The National Diabetes Prevention Program. The provider meets the requirements for the program. (7-1-25)T

135. – 139. (RESERVED)

140. LICENSED MIDWIFE (LM) SERVICES.
The Department will reimburse LMs for maternal and newborn services performed within the scope of their practice. This section of rule does not include services provided by a nurse midwife. (7-1-25)T

141. LM SERVICES: PARTICIPANT ELIGIBILITY.
LM services are available for participants in maternity, or newborn participants. (7-1-25)T

142. LM SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn. Antepartum, intrapartum, and postpartum maternity and newborn care are covered. Maternal or newborn services provided after the postpartum period are not covered when provided by a Certified Professional Midwife. (7-1-25)T

02. Medication. Covered medication listed in the LM formulary under IDAPA 24.26.01. (7-1-25)T

143. – 145. (RESERVED)

146. LM SERVICES: PROVIDER QUALITY ASSURANCE ACTIVITIES.
Each LM provider must maintain for Department review documentation of informed consent and practice data. (7-1-25)T

147. – 149. (RESERVED)

150. NUTRITIONAL SERVICES.
Nutritional services include intensive nutritional education, counseling, and monitoring. The need for nutritional services must be discovered by screening services and ordered by the provider. (7-1-25)T

151. – 161. (RESERVED)

162. OPTOMETRIST SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services for the diagnosis and treatment of injury or disease of the eye. (7-1-25)T

163. – 169. (RESERVED)

170. PODIATRIST SERVICES: DEFINITIONS.

01. Acute Foot Conditions. An acute foot condition means any condition that hinders normal function, threatens the individual, or complicates any disease. (7-1-25)T

02. Chronic Foot Diseases. Chronic foot diseases include: (7-1-25)T

a. Diabetes mellitus; (7-1-25)T

b. Peripheral neuropathy involving the feet; (7-1-25)T

c. Chronic thrombophlebitis; (7-1-25)T

d. Peripheral vascular disease; (7-1-25)T

e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or (7-1-25)T

f. Other conditions that have the potential to seriously or irreversibly compromise overall health. (7-1-25)T

171. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.
Participants eligible for podiatrist services are those with a(n): (7-1-25)T

01. Chronic Disease. (7-1-25)T

02. Acute Condition. An acute condition that, if left untreated, may cause an adverse outcome to the participant's health. (7-1-25)T

172. PODIATRIST SERVICES: COVERAGE AND LIMITATIONS.
Coverage for podiatrist services is limited to preventive foot care services for chronic foot conditions and acute conditions that if left untreated will result in chronic damage to the participant's foot. (7-1-25)T

173. – 179. (RESERVED)

SUB AREA: CHIS
(Sections 180-189)

180. CHIS: DEFINITIONS.

01. Assessment and Clinical Treatment Plan (ACTP). A comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies related to identified needs. (7-1-25)T

02. Aversive Intervention. Uses unpleasant physical or sensory stimuli to reduce undesired behavior. The stimuli usually cannot be avoided or is pain inducing. (7-1-25)T

03. Community. Natural, integrated environments outside the participant's home, outside of DDA center-based settings, or at school outside of school hours. (7-1-25)T

04. Developmental Disabilities Agency (DDA). (7-1-25)T

05. Duplicate Services. (7-1-25)T

a. Goals are not separate and unique to each service provided; or (7-1-25)T

b. When more than one (1) service is provided at the same time, unless otherwise authorized. (7-1-25)T

06. Fidelity. The consistent and accurate implementation of children's habilitation services in accordance with the modality, manual, protocol, or model. (7-1-25)T

181. CHIS: ELIGIBILITY REQUIREMENTS.
Participants are eligible from birth through the month of their twenty-first birthday. Participants must have a demonstrated functional need or a combination of functional and behavioral needs that require intervention services to correct or ameliorate their condition. A functional or behavioral need is determined by the Department approved screening tool when a deficit is identified in three (3) or more of the following areas: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency; or maladaptive behavior. A deficit is defined as one-point-five (1.5) or more standard deviations below the mean for functional areas or above the mean for maladaptive behavior. (7-1-25)T

182. CHIS: COVERAGE AND LIMITATIONS.

01. Service Delivery. CHIS may be delivered in the community, the participant's home, or in a DDA. Duplication of services is not reimbursable. (7-1-25)T

02. Required Order. CHIS must be ordered by a provider within their scope of practice. (7-1-25)T

a. CHIS providers cannot seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated order. (7-1-25)T

b. The order is only required to be completed once and must be received prior to submitting the initial PA request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, a new order is required. (7-1-25)T

03. Required Screening. Needs are determined through the current version of the Department-approved screening tools. The tool is only required to be completed once and must be completed prior to submitting the initial PA request. New screenings are required for participants who have not accessed CHIS for more than three hundred sixty-five (365) calendar days. (7-1-25)T

04. Services. All CHIS ordered on a participant's ACTP must be prior authorized by the Department. Group services must be provided by one (1) qualified staff providing direct services for two (2) or three (3) participants. As the number and needs of the participants increase, the participant ratio in the group must be adjusted from three (3) to two (2). Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. The following CHIS are reimbursable services when provided under these rules: (7-1-25)T

a. Habilitative Skill Building utilizes direct intervention techniques to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. (7-1-25)T

b. Behavioral Intervention utilizes direct intervention techniques to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs or interfering behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the participant. Services include individual or group interventions. (7-1-25)T

c. Interdisciplinary Training is a companion service to behavioral intervention and habilitative skill building and assists with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a provider. (7-1-25)T

d. Crisis Intervention includes providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis not to exceed thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: (7-1-25)T

i. Hospitalization; (7-1-25)T

ii. Out-of-home placement; (7-1-25)T

iii. Incarceration; or (7-1-25)T

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (7-1-25)T

e. The ACTP must contain the following: (7-1-25)T

i. Clinical interviews must be completed with the parent or legal guardian; (7-1-25)T

ii. Objective and validated comprehensive skills or developmental assessment. The most current assessment must be used and be from within the last year; (7-1-25)T

iii. Review of assessments, reports, and relevant history; (7-1-25)T

iv. Observations in at least one (1) environment; (7-1-25)T

v. Clinical summary and recommendations; (7-1-25)T

vi. A transition plan; and (7-1-25)T

vii. Be signed by the individual completing the assessment and the parent or legal guardian. (7-1-25)T

f. Case Management is available to assist participants accessing CHIS by the Department as described in the Medicaid Provider Handbook. (7-1-25)T

183. CHIS: PROCEDURAL REQUIREMENTS.
All CHIS identified on a participant's ACTP must be prior authorized by the Department and maintained in each participant's file. CHIS providers are responsible for documenting and submitting the ACTP and obtain PA before delivering any CHIS. (7-1-25)T

01. Prior Authorization (PA) Request. Must be submitted to the Department. The provider, and parent or legal guardian will be notified of the decision. (7-1-25)T

a. Once the initial request for PA is submitted, CHIS may be delivered for a maximum of twenty-four (24) hours and up to thirty (30) calendar days or until the PA is approved. (7-1-25)T

b. Initial PA requests must include: (7-1-25)T

i. An order from a provider; and (7-1-25)T

ii. The ACTP. (7-1-25)T

c. Ongoing PA requests must include: (7-1-25)T

i. A list of the participant's goals and objectives; (7-1-25)T

ii. A written summary of data regarding progress or lack of progress to meeting each objective, including graphs showing change lines; (7-1-25)T

iii. A list of all CHIS hours being requested and the qualification of the individual(s) who will provide them; and (7-1-25)T

iv. An updated annual ACTP, if applicable. (7-1-25)T

d. The following services may be requested retroactively: (7-1-25)T

i. The initial ACTP; (7-1-25)T

ii. The screening tool; and (7-1-25)T

iii. Crisis intervention within seventy-two (72) hours of the service initiation. (7-1-25)T

02. Implementation Plan(s). A qualified provider will complete and sign an implementation plan with details on how intervention will be implemented. All implementation plan objectives must be related to a need identified on the ACTP. The provider must document that a copy of the participant's implementation plan(s) was offered to the participant's parent or legal guardian. Any restrictive or aversive interventions being implemented must be reviewed and approved by a licensed or certified individual working within the scope of their practice. (7-1-25)T

03. Documentation. For each participant, the following program documentation is required for each visit made or service provided: (7-1-25)T

a. Date, time, and duration; (7-1-25)T

b. Summary of session or service provided, and if interdisciplinary training is provided, who the service was delivered to, and the content covered; (7-1-25)T

c. Data documentation that corresponds to the implementation plans for habilitative skill building or behavioral intervention; (7-1-25)T

d. Location of service delivery; and (7-1-25)T

e. Signature of the individual providing the service, date signed, and credential. (7-1-25)T

04. Supervision. Supervision includes both face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. Supervision must be provided under the requirements of the EBM or each provider qualification. Intervention specialists providing services to children birth to three (3) years old must be supervised by a specialist or professional who also meets the birth to three (3) years old requirements. (7-1-25)T

184. CHIS: PROVIDER QUALIFICATIONS AND DUTIES.
CHIS are delivered by individuals who meet one (1) of the qualifying criteria below and are employed by a DDA, or who meet the criteria for enrolling as an independent CHIS provider. (7-1-25)T

01. Crisis Intervention Technician. Crisis intervention technician is an employee of a DDA that can deliver crisis intervention directly with the eligible participant and meets the qualifications of a community-based supports staff. The technician must be under the supervision of a specialist or professional who is observing and reviewing the direct crisis intervention services performed. Supervision must occur monthly. (7-1-25)T

02. Intervention Technician. Intervention technicians can deliver habilitative skill building, behavioral intervention, and crisis intervention. The technician must be an employee of a DDA and be under the supervision of a specialist or professional who is observing and reviewing the services performed. Supervision must occur monthly. As a provisional position status is limited to a single eighteen (18) successive month period. Providers are qualified who are working towards meeting the experience and competency requirements for an intervention specialist or higher. (7-1-25)T

03. Intervention Specialist. Intervention specialists can deliver all CHIS, complete assessments and implementation plans, and must be under the supervision of a specialist or professional who is observing and reviewing the services performed. Supervision must occur monthly. A specialist who will complete assessments or supervise an individual completing assessments must have a minimum of ten (10) hours of documented training and five (5) hours of supervised experience in completing comprehensive assessments and implementation plans for participants with functional or behavioral needs. Qualifications are as follows: (7-1-25)T

a. Hold a Habilitative Intervention Certificate of Completion in Idaho. These providers will be allowed to continue providing services as an intervention specialist if there is not a gap of more than three (3) successive years of employment as an intervention specialist; or (7-1-25)T

b. Hold a bachelor's degree from an accredited institution in a human services field or a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field; and (7-1-25)T

i. Can demonstrate one thousand forty (1,040) hours of supervised experience working with participants birth to twenty-one (21) years of age who demonstrate functional or behavioral needs; and (7-1-25)T

ii. Meets the competency requirements by completing one (1) of the following: (7-1-25)T

(1) A Department-approved competency checklist; or (7-1-25)T

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training. (7-1-25)T

04. Intervention Professional. Intervention professionals can deliver all CHIS and complete assessments and implementation plans. Qualifications are as follows: (7-1-25)T

a. Hold a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline and have a minimum of twenty-four (24) upper-division semester credits from an accredited college or university of relevant coursework in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and (7-1-25)T

b. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (7-1-25)T

05. Evidence-Based Model (EBM) Intervention Paraprofessional. EBM intervention paraprofessionals can deliver habilitative skill building, crisis intervention, and behavioral intervention, and must be supervised in accordance with the EBM. Providers must hold a para-level certification or credential in an EBM approved by the Department. (7-1-25)T

06. Evidence-Based Model (EBM) Intervention Specialist. EBM intervention specialists can deliver all CHIS and complete assessments and implementation plans. Specialists must be supervised according to the EBM and may supervise EBM paraprofessionals working within the same EBM. Providers must hold a bachelor-level certification or credential in an EBM approved by the Department. (7-1-25)T

07. Evidence-Based Model (EBM) Intervention Professional. EBM intervention professionals can deliver all CHIS and complete assessments and implementation plans. Providers must hold a masters-level degree and certification or credential in an EBM approved by the Department. (7-1-25)T

08. Independent CHIS Provider. Independent CHIS Providers can deliver all types of CHIS, complete assessments and implementation plans according to their provider qualification as Intervention Specialists, Intervention Professionals, EBM Intervention Specialists, and EBM Intervention Professionals. Documentation of supervision must be maintained in accordance with the Department's record retention requirements. The following must be met: (7-1-25)T

a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; (7-1-25)T

b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; (7-1-25)T

c. Follow all applicable requirements in the CHIS sections; and (7-1-25)T

d. Not receive supervision from an individual that they are directly supervising. (7-1-25)T

09. Continuing Training Requirements. CHIS providers must complete a minimum of twelve (12)

hours of training each calendar year, including one (1) hour of ethics and six (6) hours of behavior methodology or evidence-based intervention. Continuing training requirements for new independent providers or employees of a DDA who have not provided CHIS for a full calendar year, may be prorated. (7-1-25)T

10. Intervention Specialists. Individuals acting as an intervention specialist or professional and who provide services to children birth to three (3) years of age must also demonstrate a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. (7-1-25)T

a. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or (7-1-25)T

b. A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate; or (7-1-25)T

c. This individual must have a minimum of twenty-four (24) semester credits from an accredited college or university, which can be within their bachelor's or master's degree coursework or can be in addition to the degree coursework. Courses must cover the following: (7-1-25)T

i. Promotion of development and learning for children from birth to five (5) years of age. (7-1-25)T

ii. Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; (7-1-25)T

iii. Building family and community relationships to support early interventions; (7-1-25)T

iv. Development of appropriate curriculum for young children; (7-1-25)T

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and (7-1-25)T

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-25)T

185. CHIS: PROVIDER REIMBURSEMENT.
The reimbursement rates calculated for CHIS include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location. (7-1-25)T

186. CHIS: QUALITY ASSURANCE.
The Department will establish performance criteria to meet federal assurances that measure the outcomes and effectiveness of CHIS. (7-1-25)T

01. Quality Assurance. Quality assurance reviews assure compliance with the Department's rules and regulations for CHIS. Identified problems that impact health and safety or are not resolved through quality improvement activities, will have implementation of a corrective action process. (7-1-25)T

02. Quality Improvement. Activities may include any of the following: (7-1-25)T

a. Consultation; (7-1-25)T

b. Technical assistance and recommendations; or (7-1-25)T

c. A Corrective Action. A formal process used by the Department to address significant, ongoing, or unresolved deficient practices identified during the review process under these rules. Corrective action includes:

(7-1-25)T

i. Issuance of a corrective action plan; (7-1-25)T

ii. Reporting to Medicaid Program Integrity Unit; or (7-1-25)T

iii. Action against a provider agreement. (7-1-25)T

187. – 189. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 190-199)

190. PREVENTIVE HEALTH ASSISTANCE (PHA): DEFINITIONS.
Behavioral PHA are benefits to support weight control. (7-1-25)T

191. PREVENTIVE HEALTH ASSISTANCE (PHA): PARTICIPANT ELIGIBILITY.

01. Behavioral PHA. The participant must have their PCP determine eligibility for Behavioral PHA. The participant qualifies by meeting one (1) of the following: (7-1-25)T

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. (7-1-25)T

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. (7-1-25)T

02. Wellness PHA. A participant who is required to pay premiums for eligibility under SCHIP. (7-1-25)T

192. PREVENTIVE HEALTH ASSISTANCE (PHA): COVERAGE AND LIMITATIONS.

01. Point System. The PHA benefit uses a point system to track points earned and used by a participant. Each point equals one (1) dollar. (7-1-25)T

a. Maximum Benefit Points. (7-1-25)T

i. The maximum number of points for a Behavioral PHA is two hundred (200) each benefit year. (7-1-25)T

ii. The maximum number of points for the Wellness PHA benefit is one hundred twenty (120) each benefit year. (7-1-25)T

b. Points expire at the end of the participant's benefit year. (7-1-25)T

c. Points cannot be transferred to, or combined with, points in another participant's PHA benefit. (7-1-25)T

02. Weight Management Program. Each program must provide weight management services with at least one (1) of the following: (7-1-25)T

a. Physical fitness; (7-1-25)T

b. Balanced diet; or (7-1-25)T

c. Personal health education. (7-1-25)T

03. Premiums. Wellness PHA benefit points are only used to offset a participant's premiums to maintain eligibility under IDAPA 16.03.01, if applicable. Only ten (10) points may be applied per month. (7-1-25)T

193. PREVENTIVE HEALTH ASSISTANCE (PHA): PROCEDURAL REQUIREMENTS.

01. Behavioral PHA. A participant must complete a PHA Benefit Agreement Form to earn two hundred (200) points. (7-1-25)T

02. Wellness PHA. Each participant must demonstrate that they have received recommended wellness visits and immunizations for their age prior to earning any points. Ten (10) points can be earned each month by for receiving all recommended wellness visits and immunizations for their age during the benefit year. (7-1-25)T

194. (RESERVED)

195. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER REIMBURSEMENT.
The provider may bill the participant for the difference between the Department's reimbursement and the provider's usual and customary charge for provided Behavioral PHA products or services with the prior agreement of the participant. (7-1-25)T

196. EARLY INTERVENTION SERVICES.
Early Intervention Services for participants are provided by the Idaho Infant Toddler Program (ITP). Services are coordinated through an intra-agency agreement published on the Department's website. Reimbursement is in accordance with the intra-agency agreement. (7-1-25)T

197. – 199. (RESERVED)

SUB AREA: LABORATORY AND RADIOLOGY SERVICES
(Sections 200-209)

200. LABORATORY AND RADIOLOGY SERVICES: DEFINITIONS.

01. Independent Laboratory. A laboratory not located in a provider's office and that receives specimens from a source other than another laboratory. (7-1-25)T

02. Laboratory or Clinical Laboratory. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body to provide information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. (7-1-25)T

03. Proficiency Testing. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. (7-1-25)T

04. Quality Control. Analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and an acceptable system to assure proper functioning of instruments, equipment, and reagents. (7-1-25)T

05. Reference Laboratory. A laboratory that only accepts specimens from other laboratories. (7-1-25)T

201. – 202. (RESERVED)

203. LABORATORY AND RADIOLOGY SERVICES: COVERAGE AND LIMITATIONS.

01. Laboratory Services. (7-1-25)T

02. Radiology Services. (7-1-25)T

204. LABORATORY AND RADIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Laboratory and Radiology Requirements. Providers of laboratory and radiology services must be eligible for Medicare certification for these services. (7-1-25)T

02. Use of Reference Laboratories. Laboratories using reference laboratories must ensure that all requirements of these rules are met by the reference laboratory. (7-1-25)T

205. LABORATORY AND RADIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Provider of Service. Payment for laboratory tests can only be made to the actual provider of that service, except in the case of: (7-1-25)T

a. An independent laboratory that can bill for a reference laboratory; (7-1-25)T

b. A transplant facility that can bill for histocompatibility testing; and (7-1-25)T

c. Healthcare professionals acting within the licensure and scope of their practice to comply with Section 39-909, Idaho Code. (7-1-25)T

02. Specimen Collection Fee. Collection fees for specimens drawn by venipuncture or catheterization are payable only to the provider or laboratory who draws the specimen. If done during an office visit on the same day the service is ordered, specimen collection is reimbursable even if PA is not approved. (7-1-25)T

206. LABORATORY AND RADIOLOGY SERVICES: QUALITY ASSURANCE.
Laboratories, as a condition of payment, must maintain a quality-control program, including proficiency testing under 42 USC Section 263a. The laboratory must provide the results to the Department upon request. (7-1-25)T

207. – 209. (RESERVED)

**SUB AREA: PRESCRIPTION DRUGS
(Sections 210-219)**

210. PRESCRIPTION DRUGS: DEFINITIONS.
Unit Dose: Drugs packaged in individual, sealed doses with tamper-evident packaging such as, but not limited to, single unit-of-use, blister packaging, unused injectable vials, and ampules. (7-1-25)T

211. PRESCRIPTION DRUGS: PARTICIPANT ELIGIBILITY.
All participants are eligible for prescription drug coverage. Medicaid will also pay for Medicaid-covered drugs that are not covered by Medicare Part D. for dual eligibles, subject to the same limits and processes used for other Medicaid participants. (7-1-25)T

212. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. Medicaid covers prescription drugs not excluded under this rule that are legally obtainable by the order of a prescriber under Section 54-1705, Idaho Code. (7-1-25)T

02. Preferred Drug List (PDL). (7-1-25)T

a. The PDL identifies preferred drugs and non-preferred drugs within a therapeutic class designated by the Department and reviewed by the Pharmacy and Therapeutics Committee (P&T Committee). (7-1-25)T

b. A brand name drug may be designated as a preferred drug by the Department if the net cost of the brand name drug after consideration of all rebates is less than the cost of the generic equivalent. (7-1-25)T

c. The Director makes final decisions regarding the designated preferred or non-preferred status of drugs based on therapeutic recommendations from the P&T Committee and cost analysis from the Medicaid

Pharmacy Program. (7-1-25)T

03. Covered Drug Products. Medicaid provides coverage to participants for the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the SSA: (7-1-25)T

a. Agents, when used to promote smoking cessation. (7-1-25)T

b. Prescription vitamins and mineral products. Covered agents include the following: (7-1-25)T

i. Injectable vitamin B12 (cyanocobalamin and analogues); (7-1-25)T

ii. Vitamin K and analogues; (7-1-25)T

iii. Prescription vitamin D and analogues; (7-1-25)T

iv. Prescription pediatric vitamins, minerals, and fluoride preparations; (7-1-25)T

v. Prenatal vitamins for pregnant or lactating individuals; and (7-1-25)T

vi. Prescription folic acid and oral prescription drugs containing folic acid in combination with vitamin B12 or iron salts, or both, without additional ingredients. (7-1-25)T

c. Certain prescribed non-prescription products, including the following: (7-1-25)T

i. Permethrin; (7-1-25)T

ii. Oral iron salts; (7-1-25)T

iii. Disposable insulin syringes and needles; and (7-1-25)T

iv. Insulin. (7-1-25)T

d. Barbiturates. (7-1-25)T

e. Benzodiazepines. (7-1-25)T

04. Additional Criteria for Coverage. The Director, acting upon the recommendation of the P&T Committee, may determine a non-prescription drug product is covered that is therapeutically interchangeable with prescription drugs in the same pharmacological class following evidence-based comparisons of efficacy, effectiveness, clinical outcomes, and safety, and the product is deemed to be a cost-effective alternative. (7-1-25)T

05. Excluded Drug Products. Medicaid excludes from coverage the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the SSA: (7-1-25)T

a. Agents, when used for the symptomatic relief of cough and colds. (7-1-25)T

b. Agents, when used for the treatment of obesity. (7-1-25)T

c. Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. (7-1-25)T

d. Agents, when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration (FDA). (7-1-25)T

06. Additional Excluded Drugs. Drugs are not covered when ineligible for federal financial participation. (7-1-25)T

07. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month because of a single prescription except: (7-1-25)T

a. Providers may be reimbursed for up to a three (3) month supply of select medications or classes of medications for a participant who has received the same dose of the same select medication or class of medications for two (2) months or longer. The Director, acting upon the recommendation of the P&T Committee, approves the list of covered maintenance medications, which targets medications that are administered continuously rather than intermittently, are used most commonly to treat a chronic disease state, and have a low probability for dosage changes. The list of covered maintenance medications is available on the Medicaid Pharmacy website at http://medicaidpharmacy.idaho.gov. (7-1-25)T

b. Contraceptive products may be dispensed in a quantity sufficient for up to six (6) months. (7-1-25)T

213. PRESCRIPTION DRUGS: PROCEDURAL REQUIREMENTS.

01. Request for PA. (7-1-25)T

a. PA is initiated by the prescriber by submitting the request to the Department in the prescribed format. (7-1-25)T

b. Whenever possible, the Department will use automated authorization, in which claims are adjudicated at point of sale using submitted National Council for Prescription Drug Programs (NCPDP) data elements or claims history to verify the Department's authorization requirements have been satisfied, without the need for the prescriber to submit additional clinical information. (7-1-25)T

02. Response to Request. The Department will respond within twenty-four (24) hours to a request for PA of a covered outpatient prescription drug under 42 U.S.C. 1396r-8(d)(5)(A). (7-1-25)T

03. Supplemental Rebates. (7-1-25)T

a. Supplemental rebates may be one (1) factor considered in determining a drug’s preferred drug status, but secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable drugs. (7-1-25)T

b. The Department may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the SSA. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. (7-1-25)T

04. Dispensing Procedures. The following protocol is required for prescription filling: (7-1-25)T

a. Refills must be authorized by the prescriber on the original or new prescription order on file and each refill must be recorded on the prescription, logbook, computer print-out, or participant’s medication profile. Automatic refills are not allowed. All refills must be initiated by a request from the participant, prescriber, or another person, acting as an agent of the participant. Authorization for each refill must be received prior to the beginning of the filling process by the pharmacy. (7-1-25)T

b. Prescriptions must be maintained on file in pharmacies and available for immediate review by the Department upon written request. (7-1-25)T

05. Return of Unused Prescription Drugs. Drugs dispensed in unit dose packaging must be returned

to the dispensing pharmacy when the participant no longer uses the medication. The pharmacy that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the professional dispensing fee. (7-1-25)T

214. PRESCRIPTION DRUGS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Enrollment. Pharmacies will enroll with the Department using the specific location where the service was performed. (7-1-25)T

02. Out-of-State Providers. An out of state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy. (7-1-25)T

215. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.
Medicaid pharmacies are reimbursed based on Actual Acquisition Costs (AAC) except where noted. Medicaid may require providers to supply documentation of their AACs under the Medicaid Pharmacy Claims Submission Manual available at: https://idaho.fhsc.com/downloads/providers/IDRx_Pharmacy_Claims_Submission_Manual.pdf. Reimbursement is restricted to drugs supplied from labelers participating in the CMS Medicaid Drug Rebate Program. (7-1-25)T

01. Pharmacy Reimbursement. Prescriptions not filled according to dispensing procedures will be subject to nonpayment or recoupment. The following protocol is required for reimbursement. (7-1-25)T

a. Reimbursement is limited to the lowest of the following: (7-1-25)T

i. AAC based on results of the periodic state cost survey under this rule, plus professional dispensing fee. In cases where no AAC is available, reimbursement will be the Wholesale Acquisition Cost (WAC). WAC is the price, for a given calendar quarter, paid by a wholesaler for the drugs purchased from the wholesaler's supplier. The wholesaler's supplier is typically the manufacturer of the drug as published by a recognized compendium of drug pricing for the same calendar quarter; (7-1-25)T

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus professional dispensing fee; (7-1-25)T

iii. Federal Upper Limit (FUL), as established by CMS, plus professional dispensing fee; or (7-1-25)T

iv. The provider's usual and customary charge to the general public. (7-1-25)T

b. The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug AACs in establishing a pharmacy reimbursement fee schedule. Pharmacies participating in the Medicaid Pharmacy Program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs. A pharmacy that is non-responsive to the periodic state cost surveys can be disenrolled as a Medicaid provider by the Department. (7-1-25)T

c. Provider Administered Drugs. (7-1-25)T

i. Reimbursement to providers that are not 340B-covered entities for medications administered to participants by providers will be: (7-1-25)T

(1) Ninety percent (90%) of the published Medicare Average Sales Price plus six percent (6%) rate (ASP+6% rate). (7-1-25)T

(2) If the ASP+6% rate is not available, payment will be at the WAC. (7-1-25)T

(3) If the ASP and WAC are not available, an invoice from the manufacturer or wholesaler is required, reimbursement will be at cost plus ten percent (10%). Radiopharmaceuticals will be paid additionally for the cost of shipping. (7-1-25)T

ii. Reimbursement to 340B covered entities for medications administered to participants by providers will be the actual 340B drug AAC, not to exceed the 340B ceiling price. (7-1-25)T

d. Clotting Factors. (7-1-25)T

i. Reimbursement to specialty pharmacies will be at a state-based price equivalent to the published Medicare ASP+6% rate, plus professional dispensing fee. (7-1-25)T

ii. Reimbursement to Hemophilia Treatment Centers will be the 340B AAC, not to exceed the 340B ceiling price. (7-1-25)T

e. Professional Dispensing Fee is a tier-based amount paid on a pharmacy claim, over and above the ingredient cost, to compensate the provider for the pharmacist's professional services related to dispensing a prescription to a participant, including: (7-1-25)T

i. Verifying a participant's coverage; (7-1-25)T

ii. Performing drug use reviews and preferred drug list review activities; (7-1-25)T

iii. Measuring or mixing the covered outpatient drug; (7-1-25)T

iv. Filling the container; (7-1-25)T

v. Participant counseling; (7-1-25)T

vi. Physically providing the completed prescription to the participant; (7-1-25)T

vii. Special packaging; and (7-1-25)T

viii. Overhead associated with maintaining the facility and equipment necessary to operate the dispensing entity. (7-1-25)T

f. Only one (1) professional dispensing fee per month is allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: (7-1-25)T

i. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (7-1-25)T

ii. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (7-1-25)T

iii. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (7-1-25)T

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (7-1-25)T

g. The Department will survey providers to establish a professional dispensing fee for each provider. The professional dispensing fees will be paid based on the provider's total annual claims volume. The provider must return the claims volume survey to the Department by May 31st each year. Providers who do not complete the survey will be assigned the lowest professional dispensing fee starting on July 1st until the next annual survey is completed. Based upon the annual claims volume of the enrolled pharmacy, the professional dispensing fee is provided online at: https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program. (7-1-25)T

02. 340B-Covered Entity Reimbursement. (7-1-25)T

a. Participation as a 340B-Covered Entity. Medicaid will reimburse 340B covered entities under Section 340B of the Public Health Service Act, defined in 42 U.S.C. 256b(a)(4), when the provider meets the following requirements: (7-1-25)T

i. A 340B-covered entity submits its unique 340B identification number issued by the Health Resources and Services Administration (HRSA) and a copy of its completed HRSA 340B registration to Medicaid. (7-1-25)T

ii. A provider that elects to provide drugs to Medicaid participants through the 340B drug pricing program must use 340B-covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the entity's retail pharmacy or administered in an outpatient clinic. A 340B-covered entity must ensure that a contract pharmacy does not dispense drugs, or receive Medicaid reimbursement for drugs, acquired by the 340B-covered entity through the 340B drug pricing program. An entity that does not comply will be carved out of the 340B drug pricing program. (7-1-25)T

iii. A 340B-covered entity must provide Medicaid with thirty (30) days written notice of its intent to discontinue the provision of drugs acquired through the 340B drug pricing program to participants. (7-1-25)T

b. Drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies are not covered. (7-1-25)T

c. Reimbursement to 340B-covered entities is limited to their actual 340B drug AAC submitted, not to exceed the 340B ceiling price, plus professional dispensing fee. (7-1-25)T

03. Reimbursement for Drugs Dispensed by Other Provider Types. (7-1-25)T

a. Drugs acquired through non-340B Indian Health Service, Tribal, or Urban Indian pharmacies will be reimbursed at the AAC to the entity, plus professional dispensing fee. (7-1-25)T

b. Drugs acquired via the Federal Supply Schedule (FSS) will be reimbursed at the FSS AAC, plus professional dispensing fee. (7-1-25)T

c. Drugs acquired at nominal price, defined as pricing that is outside of 340B regulations or FSS, will be reimbursed at the AAC, plus professional dispensing fee. (7-1-25)T

d. Specialty drugs not dispensed by retail community pharmacies and dispensed primarily through the mail will be reimbursed at the Idaho AAC, if such cost is available, plus professional dispensing fee. If the AAC is not available, drugs will be reimbursed at the lower of the WAC or SMAC as established by the Department, plus the assigned professional dispensing fee. (7-1-25)T

e. Drugs not distributed by a retail community pharmacy, such as drugs dispensed in a long-term care facility or dispensed to participants receiving swing-bed services, under these rules, will be reimbursed at the actual ingredient cost, plus professional dispensing fee. (7-1-25)T

04. Limitations on Payment. (7-1-25)T

a. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for those covered by Medicaid. (7-1-25)T

b. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. (7-1-25)T

05. Cost Appeal Process. Cost appeals will be determined by the Department's process provided online. (7-1-25)T

216. – 219. (RESERVED)

SUB AREA: FAMILY PLANNING
(Sections 220-229)

220. (RESERVED)

221. FAMILY PLANNING SERVICES: PARTICIPANT ELIGIBILITY.

01. Sterilization Procedures. Sterilization procedures are only a covered service when they meet the requirements in 42 CFR 441.253, 42 CFR 441.257, and 42 CFR 441.258. (7-1-25)T

02. Hysterectomies. Payment can be made for a hysterectomy only if: (7-1-25)T

a. The participant was advised orally and in writing that sterility would result in the inability to bear children; and (7-1-25)T

b. The participant signs and dates a form that meets the requirements of the Idaho Medicaid Provider Handbook. (7-1-25)T

c. Claims require supporting documentation attached to the claim. (7-1-25)T

222. FAMILY PLANNING SERVICES: COVERAGE AND LIMITATIONS.

Family planning includes counseling and medical services prescribed or performed by a provider. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. (7-1-25)T

01. Contraceptive Supplies. (7-1-25)T

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. (7-1-25)T

b. Payment for oral contraceptives is limited to purchase of a six (6) month supply. (7-1-25)T

02. Sterilization. (7-1-25)T

a. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are payable unless such sterilizations are ordered by a court of law. (7-1-25)T

b. Hysterectomies are subject to these rules. (7-1-25)T

c. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. (7-1-25)T

03. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the participant's signature on the consent form; and (7-1-25)T

a. In the case of premature delivery, the provider must also state the expected date of delivery and describe the emergency in detail; and (7-1-25)T

b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and (7-1-25)T

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. (7-1-25)T

04. Requirements for Sterilization Performed Due to a Court Order. The performing provider must

have been provided with a copy of the court order prior to the performance of the sterilization, and: (7-1-25)T

a. Certify that all requirements have been met concerning sterilizations; and (7-1-25)T

b. Submit a copy of the court order together with the "Consent Form" and claim. (7-1-25)T

223. FAMILY PLANNING SERVICES: PROCEDURAL REQUIREMENTS.
Informed consent exists when a properly completed "Consent Form", or its equivalent, is submitted to the Department together with the physician's claim for the sterilization. Completed informed consent forms must meet all the requirements in 42 CFR 441.258, to be eligible for reimbursement. The person obtaining informed consent must ensure and certify all the requirements in 42 CFR 441.257 have been met. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. (7-1-25)T

224. (RESERVED)

225. FAMILY PLANNING SERVICES: PROVIDER REIMBURSEMENT.
Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. (7-1-25)T

226. – 229. (RESERVED)

**SUB AREA: BEHAVIORAL HEALTH SERVICES
(Sections 230-239)**

230. (RESERVED)

231. BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
All participants eligible for Medicaid are automatically enrolled in the managed care plan to access medically necessary behavioral health services. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for inpatient services. (7-1-25)T

232. BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.
Covered services are those which evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. (7-1-25)T

233. BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Enrollment. Providers will enroll in the managed care plan with the contractor and meet both the credentialing and quality assurance guidelines of the contractor. (7-1-25)T

02. Authorization. The managed care contractor is responsible for authorization of covered behavioral health services that require PA. (7-1-25)T

03. Complaints, Grievances, and Appeals. Complaints, grievances, and appeals are handled between the contractor and the Department in compliance with state and federal requirements. Participants will utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department. (7-1-25)T

234. BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. All Services. Services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. The contractor will enter into agreements with enrolled providers to provide the services. (7-1-25)T

02. Inpatient Services. Inpatient hospital psychiatric services must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

and licensed by the state in which they provide services. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services. General hospitals licensed to provide services in their state, but are not JCAHO certified, may not bill for psychiatric services beyond emergency screening and stabilization. All inpatient services must comply with 42 CFR Part 456 when applicable. (7-1-25)T

235. BEHAVIORAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.
Provider agreements will include the reimbursement methodology agreed upon by the contractor and Department. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric services. (7-1-25)T

236. – 239. (RESERVED)

**SUB AREA: HOME HEALTH SERVICES
(Sections 240-249)**

240 – 241. (RESERVED)

242. HOME HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Services. Home health services and items include nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, audiology services, and medical supplies, equipment, and appliances provided under a home health plan of care. (7-1-25)T

02. Settings. Home health services are covered in a participant's residence and any setting in which normal life activities take place. Services are not covered in a: (7-1-25)T

a. Any setting in which Medicaid covers inpatient services, including room and board; or (7-1-25)T

b. ICF/IID, unless such services are not otherwise required to be provided by the ICF/IID. (7-1-25)T

03. Limitations. Home health services are limited to one hundred (100) visits per calendar year per person. Provision of durable medical equipment or supplies is not a visit. (7-1-25)T

04. Requirements. Services and items, when appropriate, will meet the requirements for: (7-1-25)T

a. Audiology services under these rules; (7-1-25)T

b. Medical supplies, items, and appliances under these rules; (7-1-25)T

c. Physical therapy, occupational therapy, and speech-language pathology services under these rules; and (7-1-25)T

d. Early Periodic, Screening, Diagnosis, and Treatment Services under these rules. (7-1-25)T

243. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Orders. (7-1-25)T

a. Home health services require an order including the ordering provider's NPI, the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. (7-1-25)T

b. Home health services must be reordered at least every sixty (60) days for services and annually for medical supplies, equipment, and appliances. (7-1-25)T

02. Home Health Plan of Care. All home health services must be provided under a home health plan

of care that is established prior to beginning treatment and must be signed by the provider who established the plan. (7-1-25)T

244. ELECTRONIC VISIT VERIFICATION (EVV).
Home Health Agencies (HHAs) are required to submit claims using EVV for all services provided except for the provision of medical supplies and equipment. (7-1-25)T

245. (RESERVED)

246. HOME HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. Home Health Services. Payment for home health must not exceed the lesser of reasonable cost as determined by a finalized Medicare cost report or the Medicaid percentile cap. (7-1-25)T

a. The Medicaid percentile cap is revised annually, effective at the beginning of each state fiscal year. Revisions are made using the data from the most recent finalized Medicare cost reports thirty (30) days prior to the effective date. (7-1-25)T

b. Payment by the Department for home health will include mileage as part of the visit. (7-1-25)T

c. Provider claims for services requiring EVV will include the corresponding EVV data elements. EVV data will be submitted to the state's aggregator prior to billing claims. (7-1-25)T

d. If a person is eligible for Medicare, all services ordered by the provider will be purchased by Medicare. The Department will pay for the deductible and co-insurance. (7-1-25)T

02. Medical Supplies, Equipment, and Appliances. Payment uses general procedures. (7-1-25)T

247. – 249. (RESERVED)

**SUB AREA: THERAPY SERVICES
(Sections 250-259)**

250. THERAPY SERVICES: DEFINITIONS.

01. Duplicate Services. Services are considered duplicate: (7-1-25)T

a. When participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services with treatments, evaluations, treatment plans, or goals that are not separate and unique to each service provided; or (7-1-25)T

b. When more than one (1) type of therapy is provided at the same time. (7-1-25)T

02. Feeding Therapy. Services necessary for the treatment of feeding disorders. (7-1-25)T

03. Maintenance Program. A program that requires the skills of a therapist or therapy professional and consists of activities and mechanisms to assist a participant in maximizing or maintaining the progress they have made during therapy or to prevent or slow further deterioration due to a disease or illness. (7-1-25)T

04. Occupational Therapy Services. Therapy services that: (7-1-25)T

a. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and (7-1-25)T

b. Improve the ability to perform tasks required for independent functioning. (7-1-25)T

05. Physical Therapy Services. Therapy services that: (7-1-25)T

a. Are necessary for the evaluation and treatment of physical impairment or injury using therapeutic exercise and the application of modalities to restore optimal function or normal development; and (7-1-25)T

b. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. (7-1-25)T

06. Speech-Language Pathology Services. Therapy services that are: (7-1-25)T

a. Necessary for the evaluation and treatment of speech and language disorders that result in communication disabilities; or (7-1-25)T

b. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (7-1-25)T

07. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. (7-1-25)T

08. Therapist. An individual licensed by the appropriate state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. (7-1-25)T

09. Therapy Professional. An individual licensed by the appropriate state licensing board as an occupational therapist or occupational therapist assistant, physical therapist or physical therapist assistant, or speech-language pathologist or speech-language pathology assistant. (7-1-25)T

10. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are therapy services. These services are ordered as part of a plan of care. (7-1-25)T

251. THERAPY SERVICES: PARTICIPANT ELIGIBILITY.
Participants are eligible with an evaluation showing a need for therapy due to a functional limitation, a loss or delay of skill, or both that establishes the participant will demonstrate progress because of therapy services. (7-1-25)T

252. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, NFs, school-based services, independent practitioners, and home health agencies. (7-1-25)T

01. Therapy Services. Services described in the Idaho Medicaid Provider Handbook are covered with the following limitations: (7-1-25)T

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (7-1-25)T

b. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a provider. (7-1-25)T

c. The services of therapy assistants used when providing covered benefits are included as part of the reimbursed service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services. The therapist has full responsibility for the service provided. (7-1-25)T

02. Non-Covered Therapy Services. (7-1-25)T

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement or meet the criteria for a maintenance program. (7-1-25)T

b. Services for developmentally acceptable error patterns. (7-1-25)T

c. Services that do not require the skills of a therapy professional. (7-1-25)T

d. Massage, work hardening, and conditioning. (7-1-25)T

e. Biofeedback, unless provided to treat urinary incontinence. (7-1-25)T

03. Service Limitations. (7-1-25)T

a. Therapy provided through school-based services, or the Idaho Infant Toddler Program is not included in the service limitations under this subsection. (7-1-25)T

b. Maintenance therapy is covered when an individualized assessment demonstrates that skilled care is required to carry out a safe and effective maintenance program. (7-1-25)T

253. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.
The Department will pay for therapy services rendered by a therapy professional if such services are ordered by a provider as part of a plan of care. (7-1-25)T

01. Orders. (7-1-25)T

a. Services must be reordered at least every ninety (90) days or for individuals with long-term medical conditions, as documented by a provider, at least every three hundred sixty-five (365) days. (7-1-25)T

b. Therapy services provided under home health must comply with the order requirements in home health instead. (7-1-25)T

02. Therapy Plan of Care. All therapy services must be provided under a therapy plan of care that is based on an evaluation and is established prior to beginning treatment. (7-1-25)T

a. The plan of care must be signed by the person who established the plan and sent to the ordering provider within thirty (30) days of the evaluation to continue therapy services. (7-1-25)T

b. The plan of care must be consistent with the therapy evaluation and contain: (7-1-25)T

i. Diagnoses; (7-1-25)T

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and (7-1-25)T

iii. Type, frequency, and duration of therapy services. (7-1-25)T

c. Therapy services provided under home health must comply with the home health plan of care requirements. (7-1-25)T

254. (RESERVED)

255. THERAPY SERVICES: PROVIDER REIMBURSEMENT.
The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. Reimbursement is paid as: (7-1-25)T

01. Home Health Agencies. A per visit rate. (7-1-25)T

02. Independent Therapists. Fee-for-service. A therapy assistant cannot bill Medicaid directly. (7-1-25)T

03. Hospital Services. A rate not to exceed the payment determined as reasonable cost using Medicare standards and principles. (7-1-25)T

04. Long-term Care Facilities. Bundled into the facility reimbursement for participants. (7-1-25)T

05. School-based Services. As per its subsection. (7-1-25)T

256. THERAPY SERVICES: QUALITY ASSURANCE ACTIVITIES.

01. Therapist Conditions and Requirements. The therapist is required to formulate all therapy interventions in accordance with the applicable licensure rules as well as the applicable association's professional code of ethics and standards supporting best practice. (7-1-25)T

02. Documentation. The following documentation must be maintained in the files of the provider: (7-1-25)T

a. Provider orders for therapy services; (7-1-25)T

b. Therapy plans of care; and (7-1-25)T

c. Progress or other notes documenting each assessment, therapy session, and results of tests and measurements related to therapy services. (7-1-25)T

257. – 259. (RESERVED)

**SUB AREA: AUDIOLOGY SERVICES
(Sections 260-269)**

260. AUDIOLOGY SERVICES.
Audiology services are diagnostic, screening, preventive, or corrective services provided by an audiologist, and in accordance with Title 54, Chapter 29, Idaho Code, require the order of a provider. Audiology services do not include equipment needed by the patient such as communication devices or environmental controls. (7-1-25)T

261. (RESERVED)

262. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.
All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis. Participants under the age of twenty-one (21) are eligible for routine audiometric examination and testing once per calendar year, and audiometric services and supplies as follows: (7-1-25)T

01. Non-Implantable Hearing Aids. Coverage includes, batteries purchased monthly, follow-up testing, necessary repairs not covered by warranty, the refitting of the hearing aid after the first two (2) years, and additional ear molds every six (6) months. (7-1-25)T

02. Implantable Hearing Aids. The Department covers surgically implantable hearing aids when there is a documented hearing loss and non-implantable options have been tried unsuccessfully. (7-1-25)T

03. Binaural Hearing Aids. The Department covers binaural hearing aids if documented to the Department's satisfaction, that the participant's ability to learn would be severely restricted. (7-1-25)T

263. AUDIOLOGY SERVICES: PROCEDURAL REQUIREMENTS.

01. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing. (7-1-25)T

02. Provider Documentation Requirements. Documentation of the following must be kept on file by

the provider: (7-1-25)T

a. The participant's diagnosis; (7-1-25)T

b. The results of the basic comprehensive audiometric exam that include pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and (7-1-25)T

c. The brand name and model type of the hearing aid with warranty and insurance information. (7-1-25)T

03. Warranties. Providers will exercise the use of warranties or insurance during the first year following the purchase of the hearing aid when applicable. Provider services are included in the purchase of the non-implantable hearing aid for the first two (2) years and one (1) year for implantable hearing aid including proper fitting and refitting of the ear mold or aid, instructions on the aid's use, and extended insurance coverage. (7-1-25)T

04. Waiver of Impedance Test. The Department will allow a physician or non-physician practitioner to waive the impedance test based on their documented judgment. (7-1-25)T

264. – 269. (RESERVED)

SUB AREA: DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) (Sections 270-279)

270. – 271. (RESERVED)

272. DMEPOS: COVERAGE AND LIMITATIONS.
The Department will purchase, repair, or rent medically necessary DMEPOS that are suitable for use in any setting in which normal life activities take place. Department standards for medical necessity and coverage limitations are those national standards set by Centers for Medicare and Medicaid Services (CMS) in the CMS/Medicare DME coverage manual. Exceptions are described in the Idaho Medicaid Provider Handbook. (7-1-25)T

01. Supply Coverage. The Department will purchase no more than three (3) months of necessary medical supplies in a three (3) month period. (7-1-25)T

02. New Equipment. All equipment must be new at the time of purchase, or for capped rentals, at the time of dispensing. (7-1-25)T

03. Custom Fitting. All prosthetic and orthotic devices that require fitting must be provided by a qualified provider. (7-1-25)T

04. Guaranteed Fit. Prosthetic limbs must be guaranteed to fit properly for three (3) months from the date of service; any modifications, adjustments, or replacements within the three (3) months are included in the cost of purchase. (7-1-25)T

05. Modification and Repairs. Modification to existing prosthetic or orthotic equipment is covered. Refitting, repairs, or additional parts are limited to once per calendar year for all prosthetics or orthotics unless documented that a major medical change has occurred to the limb. (7-1-25)T

06. Replacement Prosthesis or Orthotic Device. Documentation as the least costly alternative to repairing or modifying the current device is required. No replacement will be allowed within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb. (7-1-25)T

07. Corsets and Braces. Corsets and canvas braces with plastic or metal bones are not covered. Special braces enabling a participant to ambulate will be covered when a provider documents the only other method

of treatment for this condition would be a cast. (7-1-25)T

08. Electronically Powered or Enhanced Prosthetic or Orthotics. These items are non-covered. (7-1-25)T

09. Shoes and Accessories. Shoes, accessories, and modifications are not covered except when provided for the treatment of diabetes, or when attached to an orthosis or prosthesis, or when to provide for a totally or partially missing foot. (7-1-25)T

10. Temporary Lower Limb Prosthesis. Covered when documented by the ordering provider that for the participant's rehabilitation the prosthesis is necessary prior to a permanent limb prosthesis. A new permanent limb prosthesis will only be requested after the residual limb size is considered stable. (7-1-25)T

273. DMEPOS: PROCEDURAL REQUIREMENTS.

01. Orders. (7-1-25)T

a. All equipment and medical supplies must be ordered by a provider within the scope of their licensure. Orders must meet the requirements in the CMS/Medicare DME coverage manual, be kept on file with the DME provider, and include: (7-1-25)T

i. The medical diagnosis requiring the use of the item; and (7-1-25)T

ii. How long the item will be necessary and frequency of use, and for pro re nata (PRN) orders the conditions for use. (7-1-25)T

b. Medical equipment and supplies must be reordered at least annually. (7-1-25)T

c. Not more than ninety (90) days may elapse between the order date and date of a PA request. (7-1-25)T

02. Rental Procedures. When specified by the Department, equipment must be rented. (7-1-25)T

a. Rental payments, including intermittent payments, are applied to the purchase of the equipment. (7-1-25)T

b. The Department may choose to rent equipment without purchasing it. (7-1-25)T

c. The monthly rental payment will be one-tenth (1/10) of the purchase price. (7-1-25)T

274. (RESERVED)

275. DMEPOS: PROVIDER REIMBURSEMENT.

01. Items Included in Per Diem Excluded. No payment will be made for any items included in the per diem payment for inpatient care in a hospital, NF, or ICF/IID. (7-1-25)T

02. Date of Service. Unless specifically authorized by the Department, the date of services for DME and supplies is the date of delivery for items provided in-person or the date of shipment for supplies mailed through a third-party courier. (7-1-25)T

03. Warranties and Cost of Repairs. No reimbursement will be made for the cost of repairs (materials or labor) covered under the manufacturer's warranty. The date of purchase and the warranty period must be kept on file by the DME provider. The following warranty periods are required to be provided on equipment purchased by the Department: (7-1-25)T

a. An ultra-light or high-strength lightweight wheelchair must have a lifetime warranty period on the

frame and crossbraces; (7-1-25)T

b. All electrical components and new or replacement parts must have a minimum six (6) month warranty period; (7-1-25)T

c. All other DME not specified under this rule must have a minimum one (1) year warranty period; (7-1-25)T

d. If the manufacturer denies the warranty due to user misuse or abuse, that information must be forwarded to the Department at the time of the request for repair or replacement; and (7-1-25)T

e. The monthly rental payment must include a full-service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. (7-1-25)T

276. DMEPOS: QUALITY ASSURANCE.
The Department has no obligation to repair or replace any piece of DME that has been damaged, defaced, lost, or destroyed because of neglect, abuse, or misuse. (7-1-25)T

277. – 279. (RESERVED)

**SUB AREA: VISION SERVICES
(Sections 280-289)**

280. – 281. (RESERVED)

282. VISION SERVICES: COVERAGE AND LIMITATIONS.
Vision services are administered through a managed care contractor. (7-1-25)T

01. Eye Examinations. One (1) eye examination is covered during any twelve (12) month period to determine the need for glasses to correct a refractive error. (7-1-25)T

02. Eyeglasses and Contacts. Eyewear is covered when needed for correction of a refractive error. (7-1-25)T

a. Lenses will be covered once every four (4) years except when there is documentation of a major visual change. (7-1-25)T

i. Scratch resistant coating is required for all plastic and polycarbonate lenses. (7-1-25)T

ii. Tinted lenses are restricted to extreme medical conditions defined by the Department. (7-1-25)T

b. Contact lenses will be covered only for: (7-1-25)T

i. A need for correction equal to or greater than plus or minus ten (±10) diopters; or (7-1-25)T

ii. An extreme medical condition that does not allow correction using conventional lenses, such as cataract surgery, keratoconus, anisometropia, or other conditions defined by the Department. (7-1-25)T

c. One (1) set of frames is covered once every four (4) years except when receiving new lenses that do not fit in existing frames. (7-1-25)T

d. Fitting fees are covered only when the participant is eligible for the associated supplies. (7-1-25)T

03. Vision Therapy. Vision therapy is covered for participants between the ages of nine (9) and twenty-one (21) with a diagnosis of convergence insufficiency. (7-1-25)T

04. Non-Covered Items. Trifocal lenses, Progressive lenses, and photo gray. (7-1-25)T

05. Participant Responsibility. Participants are responsible for replacement of broken, lost, or missing glasses. (7-1-25)T

283. – 284. (RESERVED)

285. VISION SERVICES: PROVIDER REIMBURSEMENT.
The Department will designate a supplier to provide all eyeglass frames and lenses. (7-1-25)T

286. – 289. (RESERVED)

**SUB AREA: DENTAL SERVICES
(Sections 290-299)**

290. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.
Dental benefits are provided through a managed care contractor. (7-1-25)T

291. DENTAL SERVICES: DEFINITIONS.

01. Adults. Participants past the month of their twenty-first birthday. (7-1-25)T

02. Children. Participants from birth through the month of their twenty-first birthday. (7-1-25)T

292. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
All participants are eligible for dental benefits. (7-1-25)T

293. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Covered dental services may be subject to limitations from the managed care contractor or benefit restrictions according to the terms of its contract with the Department, in addition to these rules. (7-1-25)T

01. Dental Coverage for Children. Children are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, endodontic services (including root canals and crowns), periodontics, prosthodontic, orthodontic treatments, dentures, and oral surgery. Orthodontics are limited to children who meet Medicaid eligibility requirements as determined by the State's contractor. (7-1-25)T

02. Dental Coverage for Adults. Adults are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, periodontics, prosthodontic, dentures, oral surgery, and endodontic services with limitations. Root canals and crowns are not covered. (7-1-25)T

294. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Administer the Dental Benefit. The managed care contractor is responsible for administering the dental benefit, including dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. (7-1-25)T

02. Authorization. The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. (7-1-25)T

03. Grievances. The contractor is responsible for tracking and reporting all grievances to the State's contract monitor. (7-1-25)T

04. Appeals. Appeals are handled by a process between the contractor and the Department as specified by the Office of Administrative Hearings, and in compliance with state and federal requirements. (7-1-25)T

295. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Providers must enroll in the managed care contractor network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor, and the licensing requirements of the Idaho Board of

Dentistry standards or the applicable state in which services are provided. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (7-1-25)T

296. DENTAL SERVICES: PROVIDER REIMBURSEMENT.
The contractor reimburses dental providers on a fee-for-service basis under a Department-approved fee schedule. The State will collaborate with the contractor to establish rates that promote and ensure adequate access to dental services. (7-1-25)T

297. DENTAL SERVICES: QUALITY ASSURANCE.
Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. (7-1-25)T

298. – 299. (RESERVED)

**SUB AREA: ESSENTIAL PROVIDERS
(Sections 300-329)**

300. FQHC AND RHC SERVICES: DEFINITIONS.

01. Change in Intensity of Services. A change in the intensity of services means a change in the quantity and complexity of services delivered that could change the total allowable cost per encounter. This does not include an expansion or remodeling of an existing provider. This may include the addition of new services or the deletion of existing services. (7-1-25)T

02. Encounter. An encounter, for payment purposes, is a face-to-face contact for the provision of medical, mental or dental services between a FQHC or RHC patient and a provider as specified in Subsections 303.01 through 303.15. (7-1-25)T

03. Federally Qualified Health Centers (FQHCs). FQHCs are defined in federal law at 42 USC Section 1396d(l)(2)(A), (B), and 42 USC Section 1395x(aa)(4), and includes community health centers, migrant health centers, providers of care for the homeless, and outpatient health programs or clinics operated by a tribe or tribal organizations under the Indian Self-Determination Act (P.L. 93-638). It also includes clinics that qualify for, but are not actually receiving, grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 USC Sections 201, et seq.) that may provide ambulatory services to Medicaid participants. (7-1-25)T

04. Medicare Cost Report Period. The period of time covered by the Medicare-required annual report of cost. (7-1-25)T

05. Medicare Economic Index (MEI). An annual measure of inflation designed to estimate the increase in the total cost for the average physician to operate a medical practice and takes into account cost categories such as a physician’s own time, non-physician employee’s compensation, rents, and medical equipment. The MEI is used in establishing the annual changes to the payment conversion factors used in the methodology for determining reimbursement rates. (7-1-25)T

06. Rural Health Clinic (RHC). An RHC is located in a rural area designated as a physician shortage area and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases. (7-1-25)T

301. – 302. (RESERVED)

303. FQHC AND RHC SERVICES: COVERAGE AND LIMITATIONS.
FQHC and RHC services are defined as follows: (7-1-25)T

01. Physician Services. (7-1-25)T

02. Physician Assistant Services. (7-1-25)T

03. Nurse Practitioner or Clinical Nurse Specialist Services. (7-1-25)T

04. Visiting Nurse Services. Part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies. (7-1-25)T

05. Chiropractor Services. (7-1-25)T

06. Podiatrist Services. (7-1-25)T

07. Clinical Psychologist Services. (7-1-25)T

08. Licensed Social Worker Services. (7-1-25)T

09. Licensed Clinical Social Worker Services. (7-1-25)T

10. Licensed Masters Social Worker Services. (7-1-25)T

11. Licensed Professional Counselor Services. (7-1-25)T

12. Licensed Clinical Professional Counselor Services. (7-1-25)T

13. Licensed Marriage and Family Therapist Services. (7-1-25)T

14. Other DOPL Licenses. Any other behavioral health or substance use disorder license type recognized by the Idaho Division of Occupational and Professional Licensing (DOPL). (7-1-25)T

15. Licensed Dentist and Dental Hygienist Services. (7-1-25)T

16. Pharmacist Services. (7-1-25)T

17. Incidental Services and Supplies. Services and supplies incident to a provider listed in Subsections 303.01 through 303.15 as would otherwise be covered by a physician service are part of an encounter; or (7-1-25)T

18. Other Payable Services. Other ambulatory services covered by Medicaid that the FQHC or RHC undertakes to provide, including immunizations. These services are billed separately from an encounter. (7-1-25)T

304. – 305. (RESERVED)

306. FQHC AND RHC SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for FQHC and RHC services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42USC Section 1396a(bb), Subsections (1) through (4). (7-1-25)T

02. FQHC or RHC Encounter. Each contact with a separate discipline of health professional (medical, mental or dental), on the same day at the same location, is reimbursed as a separate encounter. All contact with all practitioners within a disciplinary category (medical, mental or dental) on the same day is a single encounter. (7-1-25)T

a. Reimbursement for services is limited to one (1) encounter per discipline per participant per day. (7-1-25)T

b. An additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later than the first encounter and requires additional diagnosis or treatment. (7-1-25)T

c. The encounter rate does not include drugs for biologicals which cannot be self-administered, long-acting reversible contraception (LARC) or non-surgical transcervical permanent female contraceptive devices. (7-1-25)T

307. FQHC AND RHC: RATE SETTING METHODOLOGY.

01. Prospective Payment System. (7-1-25)T

a. The Department will establish separate, finalized rates for medical/mental and dental encounters. The Department will prospectively set these finalized encounter rates using the FQHC's medical/mental and dental encounter costs. (7-1-25)T

b. The Department will pay each provider an encounter rate equal to the amount paid in the previous federal fiscal year. The Department will adjust the encounter rate for inflation using the Medicaid Economic Index (MEI), as published by CMS. (7-1-25)T

c. If an out-of-state FQHC becomes an Idaho Medicaid provider and provides less than one hundred (100) Idaho Medicaid encounters or receives less than ten thousand dollars ($10,000) in Idaho Medicaid payments in the first year after entering the program, the Department will deem the FQHC a low utilization provider. The finalized encounter rate for low utilization providers will be the same as the interim encounter rate as defined under these rules. If there is an increase in the number of encounters or the amount of payments over any twelve (12) month Medicare cost report period, the Department reserves the right to audit a low utilization provider's Medicare cost report in order to set a new interim encounter rate as defined under these rules. (7-1-25)T

02. New Providers to Idaho Medicaid. (7-1-25)T

a. If the provider is new, the Department will set the interim encounter rate by referring to the encounter rates paid to other providers in the same or adjacent regional areas with similar caseloads. Regional areas are defined by the Department. If encounter rate information for others in the same or adjacent regional areas with similar caseloads is not available, the Department will set the interim encounter rate using historical cost information. If historical cost information is not available, the Department will use budgeted cost and encounter information submitted by the provider. (7-1-25)T

b. If the provider has been designated as an FQHC or RHC for at least twenty-four (24) consecutive months and provides the historical cost and encounter information for this period to the Department, the Department will use the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. The Department will provide the provider a supplemental information worksheet to complete. This worksheet will be used by the Department to identify dental encounters and other incidental costs related to either medical/mental or dental encounters. (7-1-25)T

c. For both new and existing providers that become Idaho Medicaid providers, the Department will audit the Medicare cost report for the twenty-four (24) consecutive months that represent two (2) complete fiscal years after the FQHC has become a Medicaid provider. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. (7-1-25)T

d. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will adjust the finalized encounter rate annually for inflation in accordance with these rules. (7-1-25)T

e. The Department will adjust the claim payments for all provider claims paid at the interim encounter rate(s). These adjustments will reflect the payment at the finalized encounter rate(s). The Department will pay the provider for any total adjustment amount over what was reimbursed. The provider must pay the Department for any total adjustment amount that is under what was reimbursed. (7-1-25)T

03. Change in an Encounter Rate Due to a Change in Scope of Services. (7-1-25)T

a. After an approval is obtained for a change in scope of service from the federal Health Resources and Services Administration (HRSA), Bureau of Primary Health Care, the provider must request the Department to

review the encounter rate(s). This will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by the provider that could change the total cost per encounter. The provider must request the Department to review the encounter rate(s) within sixty (60) days after the approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care. (7-1-25)T

b. When the provider does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change to the scope of services, the provider must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s). The Department will review the request for a change in intensity within sixty (60) days of the planned change. (7-1-25)T

c. The Department reserves the right to audit the Medicare cost report and recalculate the encounter rates when a change in the scope of service is reported. (7-1-25)T

d. The Department will determine the encounter rate in accordance with this rule when the provider had reported a change in scope of service. The Department will audit the most recent twenty-four (24) consecutive months of Medicare cost reports following any change(s) in the scope of service. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. The finalized encounter rate(s) for both medical/mental and dental encounters will be recalculated and audited using the Medicare cost report for the second full twelve (12) month period. (7-1-25)T

04. Annual Filing Requirements. Each provider is required to file a copy of its Medicare cost report on an annual basis. Department deadlines are the same as those imposed by Medicare. (7-1-25)T

308. – 311. (RESERVED)

312. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: COVERAGE AND LIMITATIONS.
Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described for FQHC and RHC services. (7-1-25)T

313. – 314. (RESERVED)

315. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedure. Payment for services other than prescribed drugs will be made on a per visit basis at a rate not exceeding the outpatient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. (7-1-25)T

02. Dispensing Fee for Prescriptions. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. (7-1-25)T

03. Third-Party Liability Not Applicable. (7-1-25)T

316. – 319. (RESERVED)

320. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Individual Educational Plan (IEP). (7-1-25)T

02. School-Based Services (SBS). SBS are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (7-1-25)T

03. Serious and Persistent Mental Illness (SPMI). A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-5-TR with one (1) of the

following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. (7-1-25)T

321. SBS: PARTICIPANT ELIGIBILITY.

01. Age. Twenty-one (21) years of age or younger and the semester in which their twenty-first birthday falls is not finished. (7-1-25)T

02. Parental Consent. A one-time parental consent to access public benefits or insurance from a parent or legal guardian for Medicaid reimbursement. (7-1-25)T

322. SBS: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.

01. Skills Building/Community Based Rehabilitation Services (CBRS). To be eligible for Skills Building/CBRS, the student must meet one (1) of the following: (7-1-25)T

a. A student under eighteen (18) years of age meeting the Serious Emotional Disturbance (SED) eligibility criteria in the Children's Mental Health Services Act, Section 16-2403(13), Idaho Code. The child must experience a substantial impairment in functioning. The level and type of impairment must be documented in the school record. A Department-approved assessment must be used for an initial functional impairment score. Subsequent scores must be obtained annually to determine changes in functioning as a result of mental health treatment. (7-1-25)T

b. A student eighteen (18) years old or older meeting the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: (7-1-25)T

i. Vocational or educational; (7-1-25)T

ii. Financial; (7-1-25)T

iii. Social relationships or support; (7-1-25)T

iv. Family; (7-1-25)T

v. Basic living skills; (7-1-25)T

vi. Housing; (7-1-25)T

vii. Community or legal; or (7-1-25)T

viii. Health or medical. (7-1-25)T

02. CHIS. Students are eligible to receive CHIS services in accordance with EPSDT, and behavioral consultation of these rules. (7-1-25)T

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool approved by the Department that finds the student requires PCS due to a medical condition that impairs physical or functional abilities. (7-1-25)T

323. SBS: COVERAGE AND LIMITATIONS.
The Department will pay for services including medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (7-1-25)T

01. Excluded Services. (7-1-25)T

a. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. (7-1-25)T

b. Services provided more than thirty (30) days prior to the signed and dated recommendation or referral. (7-1-25)T

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (7-1-25)T

a. Be conducted by providers for the respective SBS discipline; (7-1-25)T

b. Be directed toward a diagnosis; (7-1-25)T

c. Include recommended interventions to address each need; and (7-1-25)T

d. Include name, title, and signature of the person conducting the evaluation. (7-1-25)T

03. Reimbursable Services. Providers can bill for the following health-related services provided under the recommendation of a provider for reimbursement. The recommendations or referrals are valid up to three hundred sixty-five (365) days. (7-1-25)T

a. Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified habilitative skill building needs and the student's ability to participate in educational services through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan for preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. (7-1-25)T

i. Group services provided by one (1) qualified staff providing direct services for two (2) or three (3) students. (7-1-25)T

ii. As the severity of the students with behavioral issues increases, the student ratio in the group must be adjusted from three (3) to two (2). (7-1-25)T

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (7-1-25)T

b. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. (7-1-25)T

i. Behavioral consultation cannot be provided as a direct intervention service. (7-1-25)T

ii. Behavioral consultation must be limited to thirty-six (36) hours per year. (7-1-25)T

c. Crisis intervention as defined for CHIS services. This service is provided on a short-term basis, typically not exceeding thirty (30) school days. (7-1-25)T

d. Habilitative skill building as defined for CHIS services. (7-1-25)T

e. Interdisciplinary training as defined for CHIS services. (7-1-25)T

f. Durable Medical Equipment and Supplies for use at the school where the service is provided. The equipment and supplies must be for the student's exclusive use. All equipment purchased by Medicaid belongs to the student. (7-1-25)T

g. Nursing services including emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (7-1-25)T

h. Occupational Therapy. (7-1-25)T

i. Personal Care Services (PCS). PCS include medically oriented tasks having to do with the student's physical or functional requirements. PCS do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services: (7-1-25)T

i. Basic personal care and grooming to include bathing, hair care, assistance with clothing, and basic skin care; (7-1-25)T

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bathroom routines; (7-1-25)T

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (7-1-25)T

iv. Assisting the student with provider-ordered medications that are ordinarily self-administered, under IDAPA 24.34.01; (7-1-25)T

v. Non-nasogastric gastrostomy tube feedings meeting the requirements under personal care services. (7-1-25)T

j. Physical Therapy. (7-1-25)T

k. Psychological Evaluation. (7-1-25)T

l. Psychotherapy. (7-1-25)T

m. Skills Building/Community-Based Rehabilitation Services (CBRS) are interventions to reduce the student’s disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills to prevent placement in a more restrictive situation. (7-1-25)T

n. Speech/Audiological Therapy and Evaluation. (7-1-25)T

o. Social History and Evaluation. (7-1-25)T

p. Transportation Services. Providers can receive reimbursement for mileage for transporting a student between home and school when: (7-1-25)T

i. The student requires special transportation assistance, a wheelchair lift or an attendant, when

medically necessary; (7-1-25)T

ii. The vehicle is specifically adapted to meet the needs of a disability; (7-1-25)T

iii. The student receives Medicaid-reimbursable services billed by the provider, other than transportation, on the day transportation is provided; (7-1-25)T

iv. The transportation is included on the student's plan; and (7-1-25)T

v. The mileage, as well as the services performed by the attendant, are documented. (7-1-25)T

q. Interpretive services for a student requiring an interpreter to communicate with the professional or paraprofessional providing a health-related service may be billed when services are: (7-1-25)T

i. Limited to the specific time the health-related service is received. Documentation must include the service provided. (7-1-25)T

ii. Included on the student's plan; and (7-1-25)T

iii. Provided by a professional or paraprofessional unable to communicate in the student's primary language. (7-1-25)T

324. SBS: PROCEDURAL REQUIREMENTS.
Documentation requirements: (7-1-25)T

01. IEP and Other Service Plans. Providers may bill for services covered by a current IEP, transitional Individualized Family Service Plan (IFSP), or Services Plan (SP) defined in the Idaho Special Education Manual for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be within the previous three hundred sixty-five (365) days and the need for one (1) or more medically necessary health-related service and lists all the Medicaid reimbursable services for which the provider is requesting reimbursement. The IEP and transitional IFSP must include: (7-1-25)T

a. Type, frequency, and duration of the service provided; (7-1-25)T

b. Title of the provider, including the direct care staff delivering services under the supervision of the professional; (7-1-25)T

c. Measurable goals, when goals are required for the service; and (7-1-25)T

d. Specific place of service, if provided in a location other than school. (7-1-25)T

02. Evaluations and Assessments. (7-1-25)T

03. Service Detail Reports. A service detail report that includes: (7-1-25)T

a. Name of student; (7-1-25)T

b. Name, title, and signature of the person providing the service; (7-1-25)T

c. Date, time, and duration of service; (7-1-25)T

d. Place of service, if provided in a location other than school; (7-1-25)T

e. Category of service and brief description of the specific areas addressed; and (7-1-25)T

f. Student’s response to the service when required for the service. (7-1-25)T

04. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (7-1-25)T

05. Documentation of Qualifications of Providers. (7-1-25)T

06. Recommendations or Referrals Required. SBS require a recommendation or referral within thirty (30) days of the provision of services and at least every three hundred sixty-five (365) days. (7-1-25)T

07. Requirements for Cooperation. Each provider must act in cooperation with students' parent or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. This includes: (7-1-25)T

a. Documentation that parents or guardians were notified of the services billed to Medicaid that describes the service, provider, and the type, location, frequency, and duration of the service. (7-1-25)T

b. Documentation that parents or guardian were provided with a current copy of the child's plan and any pertinent addenda. (7-1-25)T

c. Requesting the name of the student's PCP with a written consent to release and obtain information between the PCP and the school from the parent or guardian. (7-1-25)T

d. Upon receiving a request for a copy of the evaluations or the current plan, the provider furnishing the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (7-1-25)T

325. SBS: PROVIDER QUALIFICATIONS AND DUTIES.
Qualifications for covered services include licensure and acting within the scope of practice, where applicable. (7-1-25)T

01. Behavioral Intervention. Provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: (7-1-25)T

a. Intervention Paraprofessional. Provides direct services. The specialist or professional observes and reviews the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: (7-1-25)T

i. Be at least eighteen (18) years of age; (7-1-25)T

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; (7-1-25)T

iii. Meet the paraprofessional requirements under IDAPA 08.02.02. (7-1-25)T

b. Intervention Technician. As defined for CHIS services but does not need to be the employee of a DDA. (7-1-25)T

c. Intervention Specialist. Provides direct services, completes assessments, and develops implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: (7-1-25)T

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in State Board of Education Policy Section IV.B; (7-1-25)T

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an

expiration date of July 1, 2019, or later, and does not have a gap of more than three (3) years of employment as an intervention specialist; or (7-1-25)T

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: (7-1-25)T

(1) A Department-approved competency checklist referenced in the Idaho Medicaid Provider Handbook; (7-1-25)T

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (7-1-25)T

(3) Other Department-approved competencies as defined in the Idaho Medicaid Provider Handbook. (7-1-25)T

d. Intervention Professional. The services and qualifications for this provider type can be met by one (1) of the requirements for a CHIS intervention professional. (7-1-25)T

e. Evidence-Based Model (EBM) Intervention Paraprofessional. As defined for CHIS services. (7-1-25)T

f. Evidence Based Model (EBM) Intervention Specialist. As defined for CHIS services. (7-1-25)T

g. Evidence-Based Model (EBM) Intervention Professional. As defined for CHIS services provides direct services, completes assessments, develops implementation plans, and may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. (7-1-25)T

02. Behavioral Consultation. Must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program), and who meets one (1) of the following: (7-1-25)T

a. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in State Board of Education Policy Section IV.B; (7-1-25)T

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, excluding an RN or audiologist; (7-1-25)T

c. An occupational therapist; (7-1-25)T

d. An intervention professional; or (7-1-25)T

e. An EBM intervention professional. (7-1-25)T

03. Crisis Intervention. Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: (7-1-25)T

a. An intervention paraprofessional; (7-1-25)T

b. An intervention technician; (7-1-25)T

c. An intervention specialist; (7-1-25)T

d. An intervention professional; (7-1-25)T

e. An EBM intervention paraprofessional; (7-1-25)T

f. An EBM intervention specialist; (7-1-25)T

g. An EBM intervention professional; (7-1-25)T

h. A licensed physician, licensed practitioner of the healing arts; (7-1-25)T

i. An advanced practice registered nurse; (7-1-25)T

j. A licensed psychologist; (7-1-25)T

k. A licensed clinical professional counselor or professional counselor; (7-1-25)T

l. A licensed marriage and family therapist; (7-1-25)T

m. A licensed Masters social worker, licensed clinical social worker, or licensed social worker; (7-1-25)T

n. A psychologist extender; (7-1-25)T

o. An RN; (7-1-25)T

p. A licensed occupational therapist; or (7-1-25)T

q. An endorsed or certified school psychologist. (7-1-25)T

04. Habilitative Skill Building. Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following under behavioral intervention: (7-1-25)T

a. An intervention paraprofessional; (7-1-25)T

b. An intervention technician; (7-1-25)T

c. An intervention specialist; (7-1-25)T

d. An intervention professional; (7-1-25)T

e. An EBM intervention paraprofessional; (7-1-25)T

f. An EBM intervention specialist; or (7-1-25)T

g. An EBM intervention professional. (7-1-25)T

05. Interdisciplinary Training. Must be provided by one (1) of the following under behavioral intervention: (7-1-25)T

a. An intervention specialist; (7-1-25)T

b. An intervention professional; (7-1-25)T

c. An EBM intervention specialist; (7-1-25)T

d. An EBM intervention professional. (7-1-25)T

06. Medical Equipment and Supplies. (7-1-25)T

07. Nursing Services. (7-1-25)T

08. Occupational Therapy and Evaluation. Therapy rules apply. (7-1-25)T

09. Personal Care Services (PCS). Must be provided by or under the direction of an RN. (7-1-25)T

a. Providers of PCS must have at least one (1) of the following qualifications: (7-1-25)T

i. Licensed Registered Nurse (RN). (7-1-25)T

ii. Licensed Practical Nurse (LPN). (7-1-25)T

iii. Certified Nursing Assistant (CNA). (7-1-25)T

iv. Personal Assistant. A person with training to ensure the quality of services who is at least eighteen (18) years of age. (7-1-25)T

b. The RN must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care annually. Oversight provided by the RN must include all of the following: (7-1-25)T

i. Development of the written PCS plan of care; (7-1-25)T

ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and (7-1-25)T

iii. Reevaluation of the plan of care as necessary, but at least annually. (7-1-25)T

c. The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. (7-1-25)T

10. Physical Therapy and Evaluation. Therapy rules apply. (7-1-25)T

11. Psychological Evaluation. (7-1-25)T

12. Psychotherapy. (7-1-25)T

13. Skills Building/Community-Based Rehabilitation Services (CBRS). Skills Building/CBRS must be provided by one (1) of the following: (7-1-25)T

a. Licensed physician, licensed practitioner of the healing arts; (7-1-25)T

b. Advanced practice registered nurse; (7-1-25)T

c. Licensed psychologist; (7-1-25)T

d. Licensed clinical professional counselor or professional counselor; (7-1-25)T

e. Licensed marriage and family therapist; (7-1-25)T

f. Licensed master's social worker, licensed clinical social worker, or licensed social worker; (7-1-25)T

g. Psychologist extender registered with the Division of Occupational and professional Licenses; (7-1-25)T

h. Licensed registered nurse (RN); (7-1-25)T

i. Licensed occupational therapist; (7-1-25)T

j. Endorsed or certified school psychologist; (7-1-25)T

k. Skills Building/Community Based Rehabilitation Services specialist who must: (7-1-25)T

i. Be an individual who has a bachelor's degree or higher and is under the supervision of a licensed behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist monthly to review treatment provided to student participants on an ongoing basis. Supervision can be conducted using synchronous virtual care when it is equally effective as direct on-site supervision; and (7-1-25)T

ii. Have a credential required for CBRS specialists. (7-1-25)T

14. Speech/Audiological Therapy. Therapy rules apply. (7-1-25)T

15. Social History and Evaluation. (7-1-25)T

16. Transportation. Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (7-1-25)T

17. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy. The portions of the treatment plan delegated to the paraprofessional must be identified in the IEP or transitional IFSP. (7-1-25)T

326. SBS: PROVIDER REIMBURSEMENT.
Only school districts and charter schools can be reimbursed for SBS. (7-1-25)T

01. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (7-1-25)T

02. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. Providers must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: (7-1-25)T

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (7-1-25)T

b. Providers will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. (7-1-25)T

c. The Department will hold matching funds in an interest-bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. (7-1-25)T

d. The payments to the districts will include both the federal and non-federal share (matching funds). (7-1-25)T

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (7-1-25)T

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed, and reimbursement will be made during the next payment cycle. (7-1-25)T

g. The Department will provide the school districts a monthly statement that will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. (7-1-25)T

h. The school districts will estimate the amount of their next billing, and the amount of matching funds needed to pay the Department. (7-1-25)T

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (7-1-25)T

327. SBS: QUALITY ASSURANCE AND IMPROVEMENT.

01. Audit. If problems are identified during an audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department will work with the school to answer questions and provide clear direction regarding the corrective action plan. (7-1-25)T

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate student satisfaction, outcomes monitoring, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for the students. (7-1-25)T

328. – 329. (RESERVED)

**SUB AREA: MEDICAL TRANSPORTATION SERVICES
(Sections 330-349)**

330. (RESERVED)

331. EMERGENCY TRANSPORTATION SERVICES: PARTICIPANT ELIGIBILITY.
Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a participant manifests acute symptoms or signs, or both, which, by reasonable medical judgment of the Department, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. If such condition exists, and treatment is required at the participant's location, or transport of the participant for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. (7-1-25)T

332. EMERGENCY TRANSPORTATION SERVICES: COVERAGE AND LIMITATIONS.

01. Local Transport Only. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the participant was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department. (7-1-25)T

02. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (7-1-25)T

a. The point of pickup is inaccessible by land vehicle; or (7-1-25)T

b. Great distances or other obstacles are involved in getting the participant to the nearest appropriate

facility and speedy admission is essential; and (7-1-25)T

c. Air ambulance service will be covered where the participant's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (7-1-25)T

03. Co-Payments. When the Department determines that the participant did not require emergency transportation, the provider can bill the participant for the co-payment. (7-1-25)T

333. EMERGENCY TRANSPORTATION SERVICES: PROCEDURAL REQUIREMENTS.

01. Services Subject to Review. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. (7-1-25)T

02. Non-Emergency Transport PA Required. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department. The provider must provide justification to the Department that any other mode of travel would, by reasonable medical judgment of the Department, result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. (7-1-25)T

03. Air Ambulance. Air ambulance services must be approved in advance by the Department, except in emergency situations. Emergency air ambulance services will be authorized by the Department on a retrospective basis. (7-1-25)T

334. EMERGENCY TRANSPORTATION SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Licensure Required. All Emergency Medical Services (EMS) Providers must hold a current license issued by their states' EMS licensing authority. Payment will not be made to ambulances that do not hold a current license. (7-1-25)T

02. Air Ambulance. The operator of the air service must bill the Department directly. (7-1-25)T

335. EMERGENCY TRANSPORTATION SERVICES: PROVIDER REIMBURSEMENT.
Payment for ambulance services is subject to the following: (7-1-25)T

01. Ambulance Reimbursement Base Rate. (7-1-25)T

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the participant during transport. In addition to the base rate, the Department will reimburse mileage. (7-1-25)T

b. Licensed personnel are required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the following: (7-1-25)T

i. The level of personnel required to be in the patient compartment of the ambulance; (7-1-25)T

ii. The level of ambulance license the unit has been issued; and (7-1-25)T

iii. The level of life support authorized by the Department. (7-1-25)T

c. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level I (ALSI) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level II (ALSII) rate. When a participant's condition requires hospital-

to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with additional training, Specialty Care Transport (SCT) may be authorized by the Department. (7-1-25)T

02. Multiple Providers. If multiple licensed EMS providers are involved in the transport of a participant, only providers who transport the participant will be reimbursed for services. (7-1-25)T

a. In situations where personnel and equipment from a licensed ALSII provider boards an ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department. (7-1-25)T

b. In situations where personnel and equipment from a licensed ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ALSI services as authorized by the Department. (7-1-25)T

c. In situations where medical personnel and equipment from a medical facility are present during the transport of the participant, the transporting ambulance may bill at the ALSI or ALSII level of service. The transporting provider must arrange to pay the other provider for their services. (7-1-25)T

d. If multiple licensed EMS providers transport a participant for different legs of a trip, each provider must bill their base rate and mileage. (7-1-25)T

e. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department. (7-1-25)T

f. If a physician is in attendance during transport, they are responsible for the billing of their services. (7-1-25)T

03. Round Trips and Standby. (7-1-25)T

a. If an ambulance returns to a base station after having transported a participant to a facility and the participant's provider orders the participant to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. (7-1-25)T

b. Round trip charges will be allowed only when a facility in-patient is transported to the nearest facility with necessary specialized services not available in the original facility. (7-1-25)T

c. Reimbursement for waiting time will not be considered unless documentation submitted to the Department identifies the length of the waiting time and established its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. (7-1-25)T

04. Treat and Release. The Department may reimburse the EMS provider at the appropriate base rate if they respond to an emergency situation and treat and release the participant without transport. (7-1-25)T

05. Response and Evaluation. The Department may reimburse the EMS provider if they respond to a participant's location, and no treatment or transport is necessary. No payment will be made if the EMS provider responds and no evaluation is done, or the participant has left the scene. No payment will be made to an EMS provider who is licensed as a non-transporting provider. (7-1-25)T

336. – 339. (RESERVED)

340. NEMT SERVICES: DEFINITIONS.

01. Contracted Transportation Provider. A provider who is under contract with the transportation broker to provide NEMT for participants. (7-1-25)T

02. NEMT. NEMT is transportation that is: (7-1-25)T

a. Not of an emergency nature; and (7-1-25)T

b. Required for a Medicaid participant to access services covered by Medicaid when the participant's own transportation resources, family transportation resources, or community transportation resources do not allow the participant to reach those services. (7-1-25)T

03. Transportation Broker. An entity under contract with the Department to administer, coordinate, and manage a statewide network of NEMT providers. (7-1-25)T

04. Travel-Related Services. Travel-related services are meals, lodging, and attendant care required for NEMT to be completed for a Medicaid participant. (7-1-25)T

341. NEMT SERVICES: DUTIES OF THE TRANSPORTATION BROKER.
The transportation broker under contract with the Department is required to: (7-1-25)T

01. Coordinate and Manage. Coordinate and manage all NEMT services for Medicaid participants statewide. (7-1-25)T

02. Contract With Transportation Providers. Contract with transportation providers throughout the state to provide NEMT services for Medicaid participants. (7-1-25)T

03. Call Center. Operate a call center to receive and review NEMT for Medicaid participants meeting NEMT requirements. (7-1-25)T

04. Authorize NEMT Services. Authorize NEMT services for Medicaid participants requesting transportation and who meet NEMT requirements. (7-1-25)T

05. Reimburse Contracted Transportation Providers. Reimburse contracted transportation providers for NEMT services meeting the NEMT requirements. (7-1-25)T

06. Safe and Professional Transportation. Assure that contracted transportation providers deliver NEMT services in a safe and professional manner. (7-1-25)T

342. NEMT SERVICES: COVERAGE AND LIMITATIONS.

01. NEMT Services. The transportation broker will reimburse contracted transportation providers for NEMT services under the following conditions: (7-1-25)T

a. The travel is essential to get to or from a covered service; (7-1-25)T

b. The mode of transportation is the least costly that is appropriate for the medical needs of the participant; (7-1-25)T

c. The transportation is to the nearest medical provider appropriate to perform the needed services, and transportation is by the most direct route practicable; (7-1-25)T

d. Other modes of transportation, including personal vehicle, assistance by family, friends, and charitable organizations, are unavailable or impractical under the circumstances; (7-1-25)T

e. The travel is authorized and scheduled by the transportation broker; and (7-1-25)T

f. The contracted transportation provider follows the terms of its contract with the transportation broker. (7-1-25)T

02. Travel-Related Services. The transportation broker will reimburse a contracted transportation provider for travel-related services under the following circumstances: (7-1-25)T

a. The reasonable cost of meals actually incurred in transit will be reimbursed for the participant when there is no other practical means of obtaining food. (7-1-25)T

b. The reasonable cost for lodging actually incurred for the participant will be reimbursed when: (7-1-25)T

i. The round trip and the needed medical service cannot be completed in the same day; and (7-1-25)T

ii. No less costly alternative is available. (7-1-25)T

c. The reasonable cost of wages for a non-family member attendant will be reimbursed when: (7-1-25)T

i. An attendant is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (7-1-25)T

ii. No other unpaid attendant is available to accompany the participant. (7-1-25)T

d. The reasonable cost of meals actually incurred in transit will be reimbursed for one (1) family member or one (1) attendant, when: (7-1-25)T

i. Attendant care is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and (7-1-25)T

ii. There is no other practical means of obtaining food. (7-1-25)T

e. The reasonable cost of lodging actually incurred will be reimbursed for one (1) family member or one (1) attendant when: (7-1-25)T

i. An overnight stay is required to receive the service; (7-1-25)T

ii. It is medically necessary, or the vulnerability of the participant requires accompaniment for safety; and (7-1-25)T

iii. No less costly alternative is available. (7-1-25)T

343. NEMT SERVICES: REIMBURSEMENT METHODOLOGY.
The Department will reimburse the transportation broker a fixed, actuarially sound amount per member per month based on the cost of efficiently delivered, timely, and safe NEMT for eligible Idaho Medicaid participants and the cost for efficient administration of the brokerage program. (7-1-25)T

344. – 349. (RESERVED)

SUB AREA: EPSDT SERVICES
(Sections 350-359)

350. EPSDT SERVICES: DEFINITIONS.

01. Interperiodic Medical Screens. Screens done at intervals other than those identified in the American Academy of Pediatrics periodicity schedule. (7-1-25)T

02. Periodic Medical Screens. Screens done per the American Academy of Pediatrics periodicity schedule. (7-1-25)T

351. EPSDT SERVICES: PARTICIPANT ELIGIBILITY.
EPSDT services are available to participants from birth through the month of their twenty-first birthday. (7-1-25)T

352. EPSDT SERVICES: COVERAGE AND LIMITATIONS.
Services must be considered safe, effective, and meet acceptable standards of medical practice with the need for additional services documented by the screening provider as medically necessary. (7-1-25)T

01. Additional Services. Idaho Medicaid will cover services under the scope of the program as a result of an EPSDT screen regardless of inclusion in this rule or any existing amount, scope, and duration. Services must meet any applicable Department criteria and be prior authorized. (7-1-25)T

02. Interperiodic Screens. Interperiodic screens will be performed when indicated by medical necessity to determine whether a physical or mental illness or condition may require further assessment, diagnosis, or treatment. Interperiodic screens may occur for existing diagnoses when there is indication that the illness or condition may have changed sufficiently that further examination is medically necessary. (7-1-25)T

03. Eyeglasses Under EPSDT. (7-1-25)T

a. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change. (7-1-25)T

b. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one (1) of these reasons on their claim. If repair costs are greater than the cost of new frames, new frames may be authorized. (7-1-25)T

353. (RESERVED)

354. EPSDT SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Interperiodic and periodic medical screens must be performed by a physician, NP, or Physicians Assistant. (7-1-25)T

355. – 359. (RESERVED)

**SUB AREA: SPECIFIC PREGNANCY-RELATED SERVICES
(Sections 360-369)**

360. PREGNANCY-RELATED SERVICES: DEFINITIONS.

01. Individual and Family Social Services. Services directed at helping a participant to overcome social or behavioral problems that may adversely affect the outcome of the pregnancy. (7-1-25)T

02. Maternity Nursing Visit. Office visits by a licensed registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. (7-1-25)T

03. Nursing Services. Home visits by a licensed registered nurse to assess the participant's living situation and provide appropriate education and referral during the covered period. (7-1-25)T

04. Risk Reduction Follow-Up. Services to assist the participant in obtaining medical, educational, social, and other services necessary to assure a positive pregnancy outcome. (7-1-25)T

361. (RESERVED)

362. PREGNANCY-RELATED SERVICES: COVERAGE AND LIMITATIONS.
When ordered by the participant's attending provider, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. (7-1-25)T

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. (7-1-25)T

02. Maternity Nursing Visit. These services are only available to women unable to obtain a provider to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. (7-1-25)T

03. Nursing Services. Limited to two (2) visits during the covered period. (7-1-25)T

04. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a PCP for the provision of antepartum care. (7-1-25)T

05. Risk Reduction Follow-Up. (7-1-25)T

363. (RESERVED)

364. PREGNANCY-RELATED SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Risk Reduction Follow-Up. A licensed social worker, RN, nurse midwife, physician, NP, or Physician's Assistant either in independent practice or as employees of entities that have provider agreements. (7-1-25)T

02. Individual and Family Social Services. A licensed social worker qualified to provide individual counseling. (7-1-25)T

365. PREGNANCY-RELATED SERVICES: PROVIDER REIMBURSEMENT.
A single payment will be made for each month of risk reduction follow-up services provided. (7-1-25)T

366. – 449. (RESERVED)

MEDICAID ENHANCED PLAN COVERED SERVICES
(Sections 450-979)

SUB AREA: ORGAN TRANSPLANTS
(Sections 450-459)

450. – 451. (RESERVED)

452. ORGAN TRANSPLANTS: COVERAGE AND LIMITATIONS.
The Department reimburses medically necessary organ transplant services when provided by CMS approved Medicare hospitals. (7-1-25)T

453. – 454. (RESERVED)

455. ORGAN TRANSPLANTS: REIMBURSEMENT.

01. General. Organ transplant, procurement services, and follow-up care by facilities are reimbursed as specified in the provider agreement. Payment for organ procurement and histocompatibility laboratory tests is made to the facility performing the transplant. (7-1-25)T

02. Living Donor Costs. Transplant costs for actual or potential living donors are fully covered by Medicaid and include all medically necessary preparatory, operation, and post-operation recovery expenses related to the donation. Payments for a donor's post-operation expenses are limited to the actual recovery period. (7-1-25)T

456. – 459. (RESERVED)

SUB AREA: PRIVATE DUTY NURSING (PDN)
(Sections 460-469)

460. PDN: DEFINITIONS.

01. Primary RN. An RN identified by the family who develops, implements, and maintains the Service Plan. (7-1-25)T

02. PDN RN Supervisor. An RN providing oversight of PDN delegated to LPNs providing a child's care. (7-1-25)T

03. PDN Services. Nursing services provided to a non-institutionalized child under age twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary and cannot be delegated to Unlicensed Assistive Personnel (UAP). (7-1-25)T

461. PDN: PARTICIPANT ELIGIBILITY.
A child's nursing needs are such that the Idaho Nursing Practice Act, Rules, Regulations, or policy require services be provided by an RN or LPN and require more individual and continuous care unavailable from Home Health nursing services. PDN is authorized by the Department prior to service delivery. Annual redetermination is required. (7-1-25)T

01. Provider Ordered. (7-1-25)T

a. An attending provider determines the medical status is so complex or unstable that licensed or professional nursing assessment is needed to determine changes in medications or other interventions; or (7-1-25)T

b. A determination of total PDN hours needed to ensure a child's health and safety in their home. (7-1-25)T

02. RN Assessment. Identifying a child's health status for unstable chronic conditions including an evaluation of the child's responses to interventions or medications. (7-1-25)T

03. Service Plan. (7-1-25)T

a. Developed by a multi-disciplinary team including the parent or legal guardian, the primary RN, or RN Supervisor, and a Department representative; (7-1-25)T

b. Includes all medically necessary aspects of the medical and licensed services (including PCS) to be performed (amount, type, and frequency of service) ordered by the physician; (7-1-25)T

c. Approved and signed by an attending provider, parent or legal guardian, the primary RN or RN supervisor, and a Department representative; and (7-1-25)T

d. Revised at least annually and updated as a child's needs change or upon significant change of condition, submitted to the Department for review and PA of service. (7-1-25)T

04. Status Updates. Must be completed every ninety (90) days from the start of services. Annual plan reviews replace fourth quarter Status Updates. Status Updates must be signed by both the parent or legal guardian and the RN supervisor completing the form. (7-1-25)T

462. PDN: LIMITATIONS.
PDN Services are provided only in a child's personal residence or when normal life activities take a child outside of the home. If PDN is requested only to attend school or activities out of the home, but the child does not need PDN at home, PDN is not authorized. Excluded residences include NFs, ICFs/IID, Residential Assisted Living Facilities, hospitals, and public or private schools. (7-1-25)T

463. (RESERVED)

464. PDN: PROVIDER QUALIFICATIONS AND DUTIES.

01. PDN Redetermination. The primary RN is responsible for submitting a current service plan to the Department at least annually or as a child's needs change. Failure to submit an updated service plan prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN. (7-1-25)T

02. Physician Responsibility. Determine if the combination of PDN along with other community resources are sufficient to ensure the child's health or safety. If these resources do not ensure the child's health and safety, notify the family and the Department to facilitate the child's admission to an appropriate facility. (7-1-25)T

03. RN Responsibilities. RN supervisors or a provider of PDN must: (7-1-25)T

a. Notify the physician immediately of any significant changes in a child's medical condition or response to PDN; (7-1-25)T

b. Notify the Department within forty-eight (48) hours or on the first business day following a weekend or holiday of any significant changes in a child's condition or a child is hospitalized at any time; (7-1-25)T

c. Evaluate changes of condition; (7-1-25)T

d. Provide PDN under the PDN service plan; and (7-1-25)T

e. Ensure copies of records are maintained in the child's home including: (7-1-25)T

i. Service delivery date and start and end times; (7-1-25)T

ii Comments on the child's response to PDN; (7-1-25)T

iii. Nursing assessment of child's status and any changes in status each shift; (7-1-25)T

iv. Services provided during each shift; and (7-1-25)T

v. Current signed Service Plan. (7-1-25)T

04. Oversight of LPNs. RN Supervisory visits occur at least once every thirty (30) days for PDN provided by an LPN. (7-1-25)T

465. – 469. (RESERVED)

SUB AREA: NURSING FACILITIES (NF)
(Sections 470-499)

470. NF: DEFINITIONS.
NF services include long term care services provided in a facility other than an institution for mental diseases (IMD). (7-1-25)T

471. NF: ELIGIBILITY.
The Department determines whether a participant meets criteria for NF services, any patient liability and whether a participant's needs can be met in alternative living situations other than residing in a NF. The participant can select any certified NF to provide the level of care (LOC) required, if approved. (7-1-25)T

01. Determination. The Department determines a participant's level of care requirement and any need for DD or mental illness (MI) active treatment during the Level II screen. (7-1-25)T

a. Adult LOC. The Department uses a standard assessment to determine adults meet one (1) of the Resource Utilization Group (RUG III) classifications. (7-1-25)T

b. Children's LOC. A child meets LOC when the age-appropriate developmental milestones, risk factors, and aggregate care or intervention needs identified in assessments indicate one (1) or more of the following applies as documented by physician's orders, progress notes, a service plan, and nursing or therapy notes: (7-1-25)T

i. A complex provider prescribed service that requires skills of an RN or licensed physical or occupational therapist or only under equivalent supervision for safe and effective delivery. (7-1-25)T

ii. The child's condition requires skilled care to sustain current capacities, regardless of their restoration potential, even when improvement is not possible. (7-1-25)T

02. Authorization. The Department does not authorize payment to any NF for care or services beyond the NF's licensed level of care or capability. The Department notifies the NF with the authorized payment for services and any patient liability prior to admission. (7-1-25)T

472. NF: PATIENT LIABILITY.
The Department reduces payment to the NF by each participant's patient liability as determined during the financial eligibility process. (7-1-25)T

473. NF: COVERAGE AND LIMITATIONS.
NFs must provide regular, health-related care and services to participants who require additional care and services due to a mental or physical condition above room, board, and supervision alone. (7-1-25)T

01. Minimum Coverage. Minimum services and supplies include: (7-1-25)T

a. Room and board; (7-1-25)T

b. Bed and bathroom linens; (7-1-25)T

c. Nursing care, including special feeding if needed; (7-1-25)T

d. Personal services; (7-1-25)T

e. Supervision when required by the patient's condition; (7-1-25)T

f. Special diets prescribed by a physician; (7-1-25)T

g. All common over-the counter medicine chest supplies; (7-1-25)T

h. Dressings. Applications using prescription medications or aseptic techniques must be completed by an RN; (7-1-25)T

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (7-1-25)T

j. Application or administration of all drugs; (7-1-25)T

k. All common disposable medical supplies; (7-1-25)T

l. Social and recreational activities; and (7-1-25)T

m. Any reusable item commonly needed by patients expected to be available in a NF, such as bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other DME. (7-1-25)T

02. Skilled Services. (7-1-25)T

a. Overall development, management, and evaluation of a resident's service plan, based on a physician's orders, when a patient's physical or mental condition or aggregate PCS tasks require technical or

professional staff to meet their needs, promote recovery, and assure medical safety. (7-1-25)T

b. Ongoing assessment of rehabilitation needs concurrent with the management of a resident's service plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, ADLs, perceptual deficits, and speech, language, or hearing disorders. (7-1-25)T

c. Professional observation and assessment of a resident's changing condition required to identify and evaluate whether treatment modification or additional medical procedures to stabilize a condition are needed. (7-1-25)T

03. Limitations. (7-1-25)T

a. Services requiring skilled nursing staff include: (7-1-25)T

i. Intravenous injections or feedings and intramuscular or subcutaneous injections required on more than one (1) shift; (7-1-25)T

ii. Nasopharyngeal feedings and aspiration; (7-1-25)T

iii. Tracheotomy aspiration; (7-1-25)T

iv. Catheter insertion, sterile irrigation, and replacement; (7-1-25)T

v. Treating extensive decubitus ulcers or other widespread skin disorders; (7-1-25)T

vi. Heat treatments specifically ordered by a physician as part of treatment and requiring nurse observation to adequately evaluate a resident's progress; and (7-1-25)T

vii. Initial phases of a regimen involving oxygen administration. (7-1-25)T

b. Services requiring physical or occupational therapists include: (7-1-25)T

i. Therapeutic exercises or activities must be performed by or under supervision to ensure resident safety and treatment effectiveness; (7-1-25)T

ii. Gait evaluation and training to restore function in a resident whose ability to walk is impaired by neurological, muscular, or skeletal abnormality; (7-1-25)T

iii. Ultrasound, short-wave, and microwave therapy treatments; and (7-1-25)T

iv. Other treatment and modalities including hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool for residents with circulatory deficiency, desensitization, open wounds, fractures, or other complications. (7-1-25)T

474. NF: PROCEDURAL RESPONSIBILITIES.
Each NF administrator, or their authorized representative must report the following information to the Department within three (3) working days of the date a NF is aware of: (7-1-25)T

01. Change of Status. Any participant readmission, discharge, or any temporary absence due to hospitalization or therapeutic home visit. (7-1-25)T

02. Changes of Resident's Income. (7-1-25)T

03. Amount Exceeded.When a resident's account exceeds one thousand eight hundred dollars ($1,800) for single participants, or two thousand eight hundred dollars ($2,800) for married couples.(7-1-25)T

04. Other Patient Financial Information. Other information about a resident's finances that

potentially affects eligibility for Medicaid. (7-1-25)T

475. PREADMISSION SCREENING AND RESIDENT REVIEW PROGRAM (PASRR).
NFs must assure that all screens are obtained and coordinated with the Department, independent mental illness (MI) evaluators, the State Mental Health Authority (SMHA) and State Intellectual Disabilities or Developmental Disabilities Authority (SDDA), and designees. (7-1-25)T

01. Level I Screening. All required Level I screens and level of care reviews are completed and submitted to the Department prior to NF admission. (7-1-25)T

02. Level II Screening.When a NF identifies an individual with MI or DD (typically through a Level I screen), they must contact the SMHA or SDDA (as appropriate), and to complete a Level II screen prior to admission, or for existing residents, to continue residing in the NF. (7-1-25)T

03. Change in Status. Resident reviews for residents with MI or DD must occur and a new determination made after any significant change in their physical or mental condition renders them incapable of responding to program interventions. NFs must notify the Department of any changes within two (2) working days of occurrence when any significant change requires new or increased specialized services. (7-1-25)T

476. NF: ELIGIBILITY COORDINATION AND SPECIALIZED SERVICE NEEDS.
When an individual identified with MI and DD is admitted to a NF, the NF must meet that individual's needs, except for specialized services. (7-1-25)T

01. Categorical Determinations. When NF level of care is determined categorical, an individual may be conditionally admitted prior to completion of a determination for specialized services. However, conditional admissions cannot exceed seven (7) days, except for respite admissions which cannot exceed thirty (30) consecutive days in a calendar year. (7-1-25)T

02. Specialized Services. Needs must be documented and included in both the resident assessment and service plan. (7-1-25)T

03. Non-Compliance Penalty. No payment is made for any services rendered by a NF prior to completion of a Level I screen and, if required, a Level II screen. (7-1-25)T

04. Appeals. A Level I determination of MI or ID is not appealable but may be disputed as part of a Level II determination appeal. (7-1-25)T

477. NF: PREPAYMENT SCREEN AND DETERMINATION OF ENTITLEMENT TO MEDICAID PAYMENT FOR NF CARE AND SERVICES.
A current Minimum Data Set (MDS) assessment is provided to the Department. Additional supporting information may be requested. In the event a required Level II screen was not completed prior to admission, entitlement for Medicaid payment is not earlier than the date of Level II screen completion, indicating NF placement is appropriate.

478. NF: PROVIDER QUALIFICATIONS AND DUTIES.

01. Application. (7-1-25)T

02. Licensure and Certification (L&C). (7-1-25)T

a. Upon receipt of a NF application, the State determines compliance with certification standards for the type of care the NF proposes to provide to Medicaid participants. (7-1-25)T

b. NFs applying to participate as a Skilled Nursing Facility must meet Medicare certification and program participation requirements before Medicaid certification. The State determines NF compliance with Medicare and recommends certification to the Medicare Agency. (7-1-25)T

c. The Department certifies to the appropriate branch of government when the State determines a NF

meets certification standards for NF care. (7-1-25)T

479. – 480. (RESERVED)

481. NF: COST LIMITS.
The Idaho Medicaid Provider Agreement Additional Terms – Nursing Facility provides requirements necessary to implement the provisions and accomplish the objectives of the NF reimbursement system. (7-1-25)T

482. NF: RATE SETTING.

01. Payments. Payments to NFs through a prospective price-based system, which includes NF-specific case mix adjustments, separate margin payments for indirect care costs and direct care costs, and applied BAF. (7-1-25)T

02. Rate Adjustment. To set rates based on each NF's CMI on a quarterly basis and establish rates reflecting the case mix of each NF's Medicaid residents as of a certain date during the prior quarter. (7-1-25)T

483. NF: PRINCIPLE FOR RATE SETTING.
Rates are set based on projected cost data from cost and audit reports for freestanding and hospital-based NFs. In general, methodology uses a cost-based prospective reimbursement system with an acuity adjustment for direct care costs, allowances for margin payments related to indirect and direct care costs, and subject to the application of a BAF. (7-1-25)T

484. NF: RATE DEVELOPMENT.
NF rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly case mix adjustments. In no case will a rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. Rates are calculated using audited cost reports for the periods ending in the calendar year two (2) years prior to each July 1, including inflation adjustments from the midpoint of the cost report period to the mid-point of a rate period, except for property costs. (7-1-25)T

485. NF: OUT-OF-STATE FACILITIES.
Medicaid reimburses for out-of-state NF placements when services are not available in Idaho to meet the medical need, or in temporary situations for safe transportation to an Idaho NF. Services are paid the per diem rate, except where noted, for the state where the NF is located. (7-1-25)T

486. NF: DISTRESSED FACILITY.

01. Department Determination. NFs in an under-served area, or addressing an under-served need, may receive an alternative rate. (7-1-25)T

02. Discretionary Factors. A NF is not guaranteed increased payment. The Department considers factors for a higher rate on a NF-by-NF basis: (7-1-25)T

a. Prudent spending patterns and cost allocation as evidenced by a Department review of the NF's accounts. (7-1-25)T

b. A NF diligently attempted to cover costs of care, hire qualified staff, and otherwise operate effectively and efficiently, but cannot due to causes beyond the NF's reasonable control. (7-1-25)T

c. The same costs of care used to determine special rates are not applied toward a determination of distressed facility status. (7-1-25)T

d. The determination of distressed status focuses on whether the NF's distress stems from patient care costs, and not expenses unrelated to patient care costs. (7-1-25)T

e. A NF's payment cannot exceed the lower of its actual costs or customary charge to private-pay

patients unless except by federal law. The Department's cost caps can be exceeded through the distressed facility process up to the federal UPL. (7-1-25)T

03. Annual Review. Distressed facility payments are short-term and redetermined for each fiscal year a NF requests a distressed facility rate. (7-1-25)T

04. Prospective Application. Only NFs currently distressed or entering a period of distress are eligible. (7-1-25)T

487. NF: REVIEWS.

01. Facility Review. The Department may send information for NF review for rate setting. The NF must confirm its accuracy in writing or communicate errors to the Department with supporting documentation. If nothing is provided, the Department may rely on other available information for rate setting. Once information is used to set rates, it is considered final unless modified by subsequent Department review. (7-1-25)T

02. Department Review. The Department may retroactively adjust a NF's rate for incorrect information and calculate an overpayment. Adjustments do not include residents who received a default classification due to incomplete or inconsistent MDS data. (7-1-25)T

488. NF: BEHAVIORAL CARE UNIT (BCU) RATES.

01. Direct Care Costs. Additional direct care costs for BCU residents remain in direct care costs subject to the direct care cost limitation. Qualifying BCU NFs may have a direct care cost limitation higher than non-BCU NFs, and do not receive an increased indirect care cost limitation. (7-1-25)T

02. New Owner. The prior owner's cost report is used for rate calculations until the new owner has a qualifying cost report. The BCU continues to qualify for the same higher direct care cost limit as the previous owner. If the BCU is discontinued, the direct care cost limit is adjusted down to match a non-BCU NF. (7-1-25)T

489. NF: BCU QUALIFICATIONS.
Facilities must meet the qualifications for a BCU described in the Idaho Medicaid Provider Agreement Additional Terms – Behavioral Care Units. (7-1-25)T

490. NF: BCU ELIGIBLE DAYS.
NFs must demonstrate BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same 60-day period, equals or exceeds a minimum of thirty percent (30%). (7-1-25)T

491. NF: SPECIAL RATES.
The Department pays NFs an addition to their daily rate when a patient's needs exceed the scope of NF services, and the cost is not adequately reflected in the calculated rates. This rate is in addition to any payments under other provisions and excluded from the computation of payments or rates under other sections of these rules. (7-1-25)T

01. Determination. The Department approves special rates per patient based on identified conditions expected to continue for more than thirty (30) days. No rate is allowed if payment for these needs is available from a non-Medicaid source. (7-1-25)T

02. Effective Date. Upon approval, a special rate is effective on the date set by the Department. (7-1-25)T

03. Reporting. Costs equivalent to payments for special rate add-on amounts are removed from cost components subject to limits and reported separately. (7-1-25)T

04. Limitation. Special rates cannot exceed a NF's charges to other patients for similar services. (7-1-25)T

05. Prospective Rate Treatment. Special rates are paid under a prospective payment system.

(7-1-25)T

06. Payment for Qualifying Residents. The Department calculates special rate add-on amounts using one (1) of the following methods: (7-1-25)T

a. For NFs operating as a one hundred percent (100%) special care unit including Medicaid residents, the direct care cost per diem is not subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of a NF's Medicaid CMI for the rate period to the NF-wide CMI for the cost reporting period. (7-1-25)T

b. The Department pays for equipment and non-therapy supplies not addressed in the coverage and limitations section in accordance with DMEPOS, as an add-on amount. (7-1-25)T

c. NFs providing care to residents who are ventilator-dependent or receive tracheostomy care are eligible to submit requests for a fixed add-on amount, in addition to the NF's rate for residents receiving this type of care. Approved requests are effective the date a resident needs this care, no earlier than sixty (60) days prior to request receipt. Add-on rates include the cost for equipment and supplies and for additional RN and CNA hours, as appropriate for each care type. Costs for equipment and supplies are adjusted annually for inflation, and skilled nursing costs are adjusted according to annual WAHR survey results. (7-1-25)T

i. The Department reviews approved add-on rates for these residents annually to ensure the add-on rate remains necessary for the resident's care needs. (7-1-25)T

ii. NFs must inform the Department when an approved add-on rate is no longer needed or a resident's special needs change. (7-1-25)T

iii. The hourly add-on rate for staffing in an out-of-state NF equals the current WAHR CNA or RN wage rate plus a benefits allowance based on annual cost report data and weighted to remove CNA minimum daily staffing time adjusted for the appropriate staff skill level. (7-1-25)T

07. Treatment of Special Rates In Future Rate Setting Periods. Special rates are established on a prospective basis as with the overall NF rate. When a cost report used to set rates contains a special add-on cost, the Department makes an adjustment to reduce costs by an amount equal to total incremental revenues, or add-on payments received by the NF during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days paid. No related adjustment is made to the NF's CMIs. (7-1-25)T

08. Special Rate for NF Ownership Change or Closure. The Department does not require a closing cost report, and reviews special rates made in the closing cost reporting period. (7-1-25)T

492. NF: OCCUPANCY ADJUSTMENT FACTOR.
The Department makes adjustments to equitably allocate fixed costs for patients when a NF fails to maintain reasonable occupancy levels. No occupancy adjustment is made against costs used to calculate a property rental rate. Adjustments are made against all other property costs: (7-1-25)T

01. Occupancy Levels. If a NF maintains an average occupancy of less than eighty percent (80%) of capacity, the total property costs not including cost paid under a property rental rate, are prorated based upon an eighty percent (80%) occupancy rate. A NF's average occupancy percentage is subtracted from eighty percent (80%) and the result is multiplied by the total fixed costs to determine nonallowable fixed costs. When a NF changes designed capacity, average occupancy for the period before and after the change is computed for each period. (7-1-25)T

02. Occupancy Adjustment. NF capacity is computed based on the greater of the largest number of beds under a NF's license during the reporting period, except when a portion of the NF was converted to use for non-routine NF activities, or a newly constructed facility enters the Medicaid Program. If a NF's designed capacity changes, the number of beds used to determine occupancy is lowered by the capacity amount converted to non-routine NF activities. New NF capacity is based on the number of beds approved by the certificate of need process

minus any capacity converted to non-routine NF activities. (7-1-25)T

03. Fixed Costs. Occupancy adjustments to fixed costs are considered allowable and reimbursable costs when reported under property cost categories. (7-1-25)T

04. Adjustment Exemption. An increase in number of beds and new NFs are not subject to an adjustment for the first six (6) months of licensure or operation. (7-1-25)T

493. NF: RECAPTURE OF DEPRECIATION.
When depreciable assets reimbursed by Medicaid based on cost are sold for an amount exceeding their net book value, depreciation is recaptured from the NF buyer in an amount equal to reimbursed depreciation or gain on the sale, whichever is less. (7-1-25)T

01. Amount Recaptured. Depreciation is recaptured in full when a sale of a depreciated NF occurs within the first five (5) years of ownership. For every year an asset is held beyond the first five (5) years, total depreciation recaptured is reduced by ten percent (10%) per year. (7-1-25)T

02. Time Frame. The Department recaptures depreciation from a NF buyer over no more than five (5) years from the sale date, with no less than one-fifth (1/5) of the total recaptured amount for each year after. (7-1-25)T

494. NF: NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPS).
NATCEP costs are outside the content of NF care and must be reported by all NFs. Costs are reported separately as exempt costs and not included in the percentile cap. (7-1-25)T

495. NF: PAYMENTS FOR TEMPORARY ABSENCES.
Limitations for payments made to reserve beds in NFs during a temporary absence if the NF charges private pay patients for reserve bed days: (7-1-25)T

01. NF Occupancy Limits. Payment for temporary absences from NFs are made according to the number of licensed and unoccupied beds. (7-1-25)T

a. Payments are not allowed for NFs with less than one hundred (100) licensed beds when five (5) or more are unoccupied. (7-1-25)T

b. Payments may be allowed for NFs with one hundred (100) or more licensed beds when the minimum occupancy rate is ninety-five percent (95%). (7-1-25)T

02. Time Limits. Payments for temporary absences are made for therapeutic home visits for residents up to three (3) days per visit, not exceeding fifteen (15) days per calendar year for days included as part of a treatment plan ordered by a provider. (7-1-25)T

03. Payment Limits. Reserve bed days payments are the lesser of seventy-five percent (75%) of the audited allowable NF costs or the rate charged to private pay residents. (7-1-25)T

496. – 499. (RESERVED)

SUB AREA: ICF/IID
(Sections 500-529)

500. (RESERVED)

501. ICF/IID: PARTICIPANT ELIGIBILITY.
Approval for services will be no earlier than the medical provider's signed and dated certification for ICF/IID level of care. (7-1-25)T

01. Required Information for Applications. (7-1-25)T

a. A complete and current medical examination within ninety (90) days of admission, signed and dated by a medical provider, primary and secondary diagnoses, medical findings and history, mental and physical functional capacity, prognosis, mobility status, and medical provider's statement certifying ICF/IID level of care is needed. (7-1-25)T

b. An initial plan of care current within ninety (90) days of admission, signed and dated by a medical provider, and includes orders for medications and treatments, diet, and professional rehabilitative and restorative services and special procedures, when needed. (7-1-25)T

c. A social evaluation current within ninety (90) days of admission, that includes condition at birth, age at onset of condition, summary of functional status, such as skills level, ADL, and family social information. (7-1-25)T

d. A psychological evaluation conducted by a provider current within ninety (90) days of admission, or infants under three (3) years old may be evaluated by a DD specialist using developmental milestones congruent with the infant's age. Evaluations include diagnosis, summary of developmental findings, mental and physical functioning capacity, and recommendations for placement and primary need for active treatment. (7-1-25)T

e. An initial plan of care developed by the admitting ICF/IID. (7-1-25)T

02. ICF/IID Eligibility Criteria. (7-1-25)T

a. Individuals with a primary DD diagnosis or a related condition and qualify based on functional limitations, maladaptive behavior, a combination of both, or medical condition significantly affects their functional level/capabilities. (7-1-25)T

b. Individual requires and receives intensive inpatient active treatment to advance or maintain their functional level. Active treatment does not include parenting activities directed toward the acquisition of age-appropriate developmental milestones, interventions that address age-appropriate limitations, or general supervision required by all children of the same age. The following criteria evaluate the need for active treatment: (7-1-25)T

i. Complete medical, social, and psychological evaluations that clearly indicate the functional level of the participant and interventions needed; and (7-1-25)T

ii. A written plan of care with initial goals and objectives, specifying further evaluations required, and training programs to be developed. (7-1-25)T

c. Individual requires the level of care provided in an ICF/IID, including active treatment, and, in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an IMD. (7-1-25)T

d. ICF/IID level of care is redetermined annually related to continued need of community services. (7-1-25)T

i. Home Care for Certain Disabled Children receive services until the end of the month their redetermination was made. When the redetermination is made less than ten (10) days from the end of a month, payment continues until the end of the following month. (7-1-25)T

ii. Individuals receiving DD waiver services have thirty (30) days from the determination to transition to other community supports. (7-1-25)T

502. ICF/IID: COVERAGE AND LIMITATIONS.
The Department pays for services in an ICF/IID whose primary purpose is providing habilitative services and maintaining optimal health status for individuals with intellectual disabilities or related conditions. (7-1-25)T

01. Coverage. The minimum content of care and services for ICF/IID residents includes: (7-1-25)T

a. Room and board; (7-1-25)T

b. Bed and bathroom linens; (7-1-25)T

c. Nursing care, including special feeding if needed; (7-1-25)T

d. Personal services; (7-1-25)T

e. Supervision; (7-1-25)T

f. Special diets as prescribed by a participant's provider; (7-1-25)T

g. All common medicinal supplies that do not require a prescription; (7-1-25)T

h. Dressings; (7-1-25)T

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (7-1-25)T

j. Application or administration of all drugs; (7-1-25)T

k. All medical supplies; (7-1-25)T

l. Social and recreational activities; and (7-1-25)T

m. Items used by individuals that are reusable and expected to be available. (7-1-25)T

02. Limitations. Specialized wheelchairs and seating systems, including repair, designed to fit the needs of a specific resident and cannot be altered to fit another resident cost effectively are not included in ICF/IID content of care. These are paid directly to the supplier. (7-1-25)T

03. Temporary Absence. Reimbursement is available for reserving beds for during a temporary absence if the facility charges private payors for reserve bed days. Therapeutic home visits are allowed for up to thirty-six (36) days per calendar year when days are part of a written treatment plan ordered by the attending physician. Prior authorization is required for any home visits exceeding fourteen (14) consecutive days. Reimbursement is the lesser of audited allowable costs, or usual and customary charges. (7-1-25)T

503. ICF/IID: PROCEDURAL RESPONSIBILITIES.

01. Reporting Requirements. Each ICF/IID administrator, or their authorized representative, must report to the Department within three (3) working days of the date the facility is aware of the following: (7-1-25)T

a. Readmissions or discharges, including any participant's temporary absence due to hospitalization or therapeutic home visit. (7-1-25)T

b. Changes to participant's income. (7-1-25)T

c. Participant's account exceeds one thousand eight hundred dollars ($1,800) for single individuals or two thousand eight hundred dollars ($2,800) for married couples. (7-1-25)T

d. Other changes to participant's finances that may potentially affect their eligibility for Medicaid. (7-1-25)T

02. Annual Recertification. ICF/IIDs must assure that participant annual recertifications are completed. (7-1-25)T

a. When Medicaid receives a federal financial penalty due to the lack of appropriate recertification on

the part of an ICF/IID, then that amount is withheld from facility payments for participants. For audit purposes, these financial losses are not a reimbursable cost of participant care and cannot be billed to the participant. (7-1-25)T

b. ICF/IID residents are transitioned to a less restrictive environments within thirty (30) days of a determination when a participant fails to meet ICF/IID level of care. (7-1-25)T

03. Supplemental On-Site Visit. The Department conducts utilization control supplemental on-site visits in an ICF/IID to review these indications to complete follow-up activities, verify a participant's appropriateness of placement or services, and conduct complaint investigations. (7-1-25)T

04. Determinations. The Department issues the final decision for eligibility and level of care, including the need for DD or MI active treatment through the Level II screening process. If eligible, the Department forwards authorization for payment to the facility chosen by the individual. The participant can select any certified facility to provide care. No payment is made to any facility for services that are beyond the facility's licensed level of care. (7-1-25)T

504. ICF/IID: PROVIDER QUALIFICATIONS AND DUTIES.

01. Direct Care Staffing Levels. A reasonable level of direct care staff provided to an ICF/IID resident is dependent upon the level of involvement and their need for services and supports as determined by the Department. Level of involvement relates to the severity of a resident's intellectual disability. Those levels, in decreasing level of severity, are profound, severe, moderate, and mild. Direct care staffing levels are limited to the following maximum hours per week: (7-1-25)T

a. Sixty-eight and twenty-five hundredths (68.25) hours for a severely and profoundly intellectually disabled resident. (7-1-25)T

b. Fifty-four and six tenths (54.6) hours for a moderately intellectually disabled resident. (7-1-25)T

c. Thirty-four and one hundred twenty-five thousandths (34.125) hours for a mildly intellectually disabled resident. (7-1-25)T

02. Direct Care Staff Hours. The annual sum level of allowable direct care staff hours for each residential living unit is determined in the aggregate as the sum total of the level of staffing allowable for each resident. (7-1-25)T

03. Phase-In Period. If these rules require a facility to reduce its direct care staffing, a six (6) month phase-in period is allowed from the date of adjustment, without any resulting disallowances. Should disallowances result, the hourly rate of direct care staff used in determining disallowances is the weighted average of the hourly rates paid to the direct care staff, plus associated benefits, at the end of the phase-in period. (7-1-25)T

505. ICF/IID: REIMBURSEMENT.

These rules do not apply to ICF/IID facilities owned or operated by the state of Idaho. ICF/IIDs are reimbursed per patient day with the ICF/IID methodology implemented by the Department. (7-1-25)T

506. (RESERVED)

507. ICF/IID: ALLOWABLE COSTS.

01. Auto and Travel Expense. (7-1-25)T

02. Bad Debts. (7-1-25)T

03. Bank or Finance Charges. (7-1-25)T

04. Compensation of Owners. (7-1-25)T

05. Contracted Service. (7-1-25)T

06. Depreciation. (7-1-25)T

07. Dues, Licenses, or Subscriptions. (7-1-25)T

08. Employee Benefits. (7-1-25)T

09. Employee Recruitment. (7-1-25)T

10. Entertainment Costs Related to Patient Care. (7-1-25)T

11. Food. (7-1-25)T

12. Home Office Costs. (7-1-25)T

13. Insurance. (7-1-25)T

14. Interest. (7-1-25)T

15. Lease or Rental Payments. (7-1-25)T

16. Malpractice or Public Liability Insurance. (7-1-25)T

17. Payroll Taxes. (7-1-25)T

18. Principle. Costs for services, facilities, and supplies furnished to the provider by organizations or persons related to a provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable when they relate to care, are reasonable, ordinary, and necessary, and do not exceed costs incurred by a prudent cost-conscious buyer. (7-1-25)T

19. Property Costs. (7-1-25)T

20. Property Insurance. (7-1-25)T

21. Repairs or Maintenance. (7-1-25)T

22. Salaries. (7-1-25)T

23. Supplies. (7-1-25)T

24. Taxes. (7-1-25)T

508. ICF/IID: NON-ALLOWABLE COSTS.

01. Accelerated Depreciation. (7-1-25)T

02. Acquisitions. (7-1-25)T

03. Charity Allowances. (7-1-25)T

04. Consultant Fees. (7-1-25)T

05. Franchise Fees. (7-1-25)T

06. Fund Raising. (7-1-25)T

07. Goodwill. (7-1-25)T

08. Holding Companies. (7-1-25)T

09. Interest to Finance Unallowable Costs. (7-1-25)T

10. Medicare Costs. (7-1-25)T

11. Non-patient Care Related Activities. (7-1-25)T

12. Organization. (7-1-25)T

13. Pharmacist Salaries. (7-1-25)T

14. Prescription Drugs. (7-1-25)T

15. Related Party Interest. (7-1-25)T

16. Related Party Non-allowable Costs. (7-1-25)T

17. Related Party Refunds. (7-1-25)T

18. Self-Employment Taxes. (7-1-25)T

19. Vending Machines. (7-1-25)T

509. (RESERVED)

510. ICF/IID: OCCUPANCY ADJUSTMENT FACTOR.
Adjustments are to equitably allocate fixed costs for Medicaid patients when a facility falls below reasonable occupancy levels. No occupancy adjustment is made against costs used to calculate the property rental rate. Adjustments are made against all other property costs: (7-1-25)T

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of capacity, the total property costs not including cost paid for property rental rate, is prorated based on an eighty percent (80%) occupancy rate. A facility's average occupancy percentage is subtracted from eighty percent (80%) and the resultant percentage is multiplied by the total fixed costs to determine non-allowable fixed costs. When a provider changes the designed capacity, the average occupancy for the period before and after the change is computed for each period. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (7-1-25)T

02. Occupancy Adjustment. Facility capacity is computed based on the greater of the largest number of beds a facility was licensed for during the reporting period or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed. If a facility's designed capacity changes, the number of beds used to determine occupancy is lowered by the capacity amount converted to non-routine ICF/IID activities. The new capacity is based on the number of beds approved by the certificate of need process less any capacity converted to non-routine ICF/IID activities. (7-1-25)T

03. Fixed Costs. Occupancy adjustment to fixed costs is considered allowable and reimbursable when reported under property cost categories. (7-1-25)T

04. New Facility. For newly licensed and occupied facilities, the first six (6) months occupancy level is not subject to an adjustment. (7-1-25)T

511. ICF/IID: RECAPTURE OF DEPRECIATION.
Depreciable assets reimbursed based on cost, and sold for an amount over net book value, are recaptured from the

facility's buyer in an amount equal to reimbursed depreciation, or gain on the sale, whichever is less. (7-1-25)T

01. Amount Recaptured. Depreciation is recaptured in full when sale of a depreciated facility occurs within the first five (5) years of ownership. For every year an asset is held beyond the first five (5) years, total depreciation recaptured is reduced by ten percent (10%) per year. (7-1-25)T

02. Time Frame. The Department recaptures depreciation from the facility buyer over no more than five (5) years from the sale date, with no less than one fifth (1/5) of the total amount recaptured each year after. (7-1-25)T

512. ICF/IID: REPORTING SYSTEM.
A uniform system of periodic reports is used to allow: (7-1-25)T

01. Basis for Reimbursement. By approximating actual costs. (7-1-25)T

02. Adequate Financial Disclosure. (7-1-25)T

03. Statistical Resources. As a basis for measuring reasonable costs and comparative analysis. (7-1-25)T

04. Criteria For Evaluating Policies and Procedures. (7-1-25)T

513. ICF/IID: REPORTING SYSTEM PRINCIPLE AND APPLICATION.
Providers must file annual cost reports. (7-1-25)T

01. Cost Report Requirements. The fiscal year end filings include: (7-1-25)T

a. Annual income statement; (7-1-25)T

b. Balance sheet; (7-1-25)T

c. Statement of ownership; (7-1-25)T

d. Schedule of patient days; (7-1-25)T

e. Schedule of private patient charges; (7-1-25)T

f. Statement of additional charges to residents above usual monthly rates; and (7-1-25)T

g. Other schedules, statements, and documents as requested. (7-1-25)T

02. Special Reports. When required, specific instructions are issued, based upon the circumstance. (7-1-25)T

03. Report Criteria. (7-1-25)T

a. Use of State-approved formats. (7-1-25)T

b. Presented on accrual basis. (7-1-25)T

c. Prepared according to GAAP and principles of reimbursement. (7-1-25)T

d. Providing appropriate detail on supporting schedules or as requested. (7-1-25)T

04. Preparer. Statements do not require a CPA. (7-1-25)T

05. Reporting by Chain Organizations or Relative Providers. Filing combined or consolidated cost

reports as a basis for reimbursement is prohibited. Each facility must file a separate set of reports for each level of organization allocating expenses to a provider. Consolidated financial statements are considered supplementary information and do not meet primary reporting requirements. (7-1-25)T

06. Change of Management or Ownership. To properly pay separate entities or individuals after a change of management or ownership, the following requirements apply: (7-1-25)T

a. Outgoing management or administration must file an adjusted-period cost report when necessary. This report will meet the criteria for annual cost reports and be filed no later than sixty (60) days after the change. (7-1-25)T

b. The Department may require an appraisal for a change in ownership. (7-1-25)T

07. Reporting Period. When required to establish rates, new ICF/IIDs are required to submit cost projections for the first year of operations. Thereafter, the normal reporting period coincides with the facility's standard fiscal year. If a facility withdraws from the program and later re-enters, new provider reporting requirements apply. (7-1-25)T

514. (RESERVED)

515. ICF/IID: PRINCIPLE PROSPECTIVE RATES.
ICF/IID are paid a per diem rate that, with certain exceptions, is not subject to audit settlements. The rate for a fiscal period is based on audited historical costs not adjusted for inflation. Facilities must report these costs. Total payments include property reimbursement, capped costs, exempt costs, and excluded costs. Rates are calculated using audited cost reports for the calendar year two (2) years prior to July 1st, with no cost or cost limit adjustments for inflation. (7-1-25)T

516. ICF/IID: PROPERTY REIMBURSEMENT.
ICF/IID property costs are reimbursed using a rental rate or based on cost. The following are reimbursed based on cost under these rules and PRM: ICF/IID living unit property taxes, living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and are not reported in the property cost portion of the cost report. These costs are reported in the home office and day treatment section of the cost report. Property costs, including costs reimbursed based on a rental rate, are reported in the property cost portion of the cost report. The Department may require and use an appraisal to establish those components identified as an integral part of an appraisal. Property costs include the following allowable components: (7-1-25)T

01. Straight-Line Depreciation. (7-1-25)T

02. Interest. (7-1-25)T

03. Property Insurance. (7-1-25)T

04. Lease Payments. (7-1-25)T

05. Property Taxes. (7-1-25)T

06. Costs of Related Party Leases. (7-1-25)T

517. ICF/IID: CAPPED COST.

01. Costs Subject to the Cap. Include all allowable costs except property costs under property reimbursement and exempt excluded costs. (7-1-25)T

02. Per Diem Costs. Costs are divided by total resident days for a facility in the cost reporting period to arrive at allowable per diem costs. If costs for services provided any non-Medicaid residents are not included in the

total costs submitted, the facility must determine these costs and combine them with submitted costs so a total per diem cost for that facility is determined for both determining the ICF/IID cap and computing final reimbursement. (7-1-25)T

03. Cost Data to Determine the Cap. Cost data from the final cost report used for rate setting, per prospective principles, will be used. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. However, the final cost reports covering a period of less than twelve (12) months are included in data to determine the cap at the option of the Department. (7-1-25)T

04. Payments to Non ICF/IIDs. Payments made by the Department directly to non-ICF/IIDs are excluded from the ICF/IID prospective rates and cap. Services covered under EPSDT or "Medicaid Basic Plan Benefits" are not included in ICF/IID costs. Providers must bill Medicaid directly for these services under their own provider number. (7-1-25)T

05. Cost Ranking. Prior to annual rate setting, the Director will determine the percent above the median used in the cap calculation. That percent will apply to the cap and rates set per prospective principles. Per diem capped costs, by facility, as determined in this section will be ranked from the highest to the lowest, with the median being the 50th percentile. The cap for the applicable rate period will not exceed the 75th percentile of these ranked per diems. (7-1-25)T

a. The median of the range is computed based on the available data points considered the total population of data points. (7-1-25)T

b. A new cap and rate are set annually for each facility July 1st. (7-1-25)T

c. The cap and prospective rate are determined and set annually for each facility July 1st and is not changed by any subsequent events or information unless the computations are found to contain mathematical or clerical errors. These errors are then corrected, and the cap is adjusted using corrected figures. (7-1-25)T

d. Payment of costs subject to the cap are limited to the cap unless the Department determines the exclusions. (7-1-25)T

518. (RESERVED)

519. ICF/IID: RETROSPECTIVE SETTLEMENT.
When applicable, settlements are based on allowable reimbursement under these rules, based on an audit report, and subject to the same caps and limits determined for prospective payments. (7-1-25)T

01. Failure to Meet Conditions. (7-1-25)T

02. First Time Provider. (7-1-25)T

03. New ICF/IID Living Unit. (7-1-25)T

04. Ownership Change. (7-1-25)T

05. Fraudulent Claims. (7-1-25)T

06. Excluded Costs. (7-1-25)T

520. ICF/IID: EXEMPT COSTS.
Day treatment services and major movable equipment costs are not subject to the ICF/IID cap. (7-1-25)T

521. ICF/IID: COSTS EXCLUDED FROM CAP.
Certain costs excluded from the ICF/IID cap are subject to retrospective settlement at the discretion of the Department, and result in changes to a prospective rate to assure equitable reimbursement: (7-1-25)T

01. Increases to Per Participant Day Costs. (7-1-25)T

02. Excess Inflation. (7-1-25)T

03. Cost Increases Over 3%. (7-1-25)T

04. Decreases. (7-1-25)T

05. Prospective Negotiated Rates. (7-1-25)T

522. (RESERVED)

523. ICF/IID: PROPERTY RENTAL RATE REIMBURSEMENT.
ICFs/IID are paid a property rental rate. Property taxes, property insurance, depreciation expense, and major moveable equipment are reimbursed as costs exempt from limitations. The property rental rate does not include compensation for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. (7-1-25)T

01. Rate Calculation. Property rental rates are based upon current construction costs, age of a facility, type of facility, and major expenditures made to improve a facility, or a rate based upon current property costs. Amounts paid for each Medicaid day of care are phased in as follows: (7-1-25)T

a. "R" = "Property Base" x forty (40) - "Age" / forty (40) x "change in building costs" where: (7-1-25)T

b. "R" = the property rental rate. (7-1-25)T

c. "Property Base": (7-1-25)T

i. Eleven dollars and twenty-two cents ($11.22) for ICF/IID with wheelchair accommodations. (7-1-25)T

ii. Seven dollars and twenty-two cents ($7.22) for ICF/IID without wheelchair accommodations. (7-1-25)T

d. "Change in building costs" = the most recent CMI available to set a prospective rate for a period including all or part of the calendar year. (7-1-25)T

e. "Age" of facility = The effective age of the facility in years is set by subtracting the year in which a facility, or a new section, was constructed from the year in which the rate is applied. No facility or new section is assigned an age over thirty (30) years, however: (7-1-25)T

i. The age is set at thirty (30) years unless documentation is received to the contrary. Adequate documentation includes, but is not limited to, copies of building permits, tax assessors' records, receipts, invoices, building contracts, and original notes of indebtedness. An age is determined for each building. A weighted average using the age and square footage of the buildings becomes the effective age of a facility. The age of each building is based upon the date when construction on that building was completed. (7-1-25)T

ii. An effective age of a facility is further adjusted when the cost of major repairs, replacements, remodeling, or renovation of a building results in a change in age by at least one (1) year when applied to this formula:

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of a facility in years.

A	=	Age of a building at the time construction was completed.
E	=	Actual expenses for construction provided the total costs were incurred within 24 months of completion of the construction.
S	=	The number of square feet in a building at the end of construction.
C	=	The cost of construction for buildings in the year construction was completed.

These changes do not decrease an effective age of a facility beyond the point where an increase in the property rental rate is more than three fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of a proposed rate revision and the property rental rate a facility was eligible for immediately before an adjustment. The cost for "C" is adjusted according to costs published by Marshall Swift Valuation Service reflecting current construction costs for average Class D convalescent hospitals. Providers must notify the Department with documented costs. The Department adjusts the age. (7-1-25)T

iii. The Department reimburses expenditures directly related to new requirements imposed by state or federal agencies, as an increase to the property rental rate if the expense exceeds one hundred dollars ($100) per bed. When costs related to a requirement are less than one hundred dollars ($100) per bed, the Department reimburses the Medicaid share of the entire cost of new requirements in a one-time payment to a facility within twelve (12) months of expense verification. (7-1-25)T

iv. "Age of facility" will be a revised age that is lesser of either the age established under this section, or the age that most closely yields the rate allowable to existing facilities. This revised age will not increase over time. (7-1-25)T

02. Facility Sale. When a facility, or asset of a facility, is sold, the buyer receives the property rental rate as calculated. (7-1-25)T

524. ICF/IID: PROPERTY REIMBURSEMENT LIMITATIONS.
Property costs of an ICF/IID are reimbursed except as follows: (7-1-25)T

01. Property Leases. No grandfathered rates or lease provisions other than the following apply: (7-1-25)T

a. Property costs related to living units other than costs for major movable equipment are paid the property rental rate. (7-1-25)T

b. Leases for property other than ICF/IID living units are allowable based on lease cost to a facility not exceeding reasonable market rate, subject to principles associated with related party leases. (7-1-25)T

02. Home Office and Day Treatment Property Costs. Distinct parts of buildings containing ICF/IID living units may be used for home office or day treatment purposes. Reimbursement for the property costs of these parts is allowed when the areas are used exclusively for these services. The portion of property cost attributed to these areas is reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for these costs does not include costs reimbursed by, or covered by the property rental rate, and are only reimbursed as property cost when the facility clearly included space in excess of space normally used in a facility. To qualify for reimbursement, a structure must have square feet per licensed bed exceeding the average square feet per licensed bed for other ICF/IID living units with four (4) licensable beds. (7-1-25)T

525. ICF/IID: SPECIAL RATES.
The Department pays special rates for care for residents with long-term medical or behavioral care needs beyond the normal scope of facility services. Payment for specialized care is in addition to any payments made under these rules and based on a per diem rate applicable to the incremental additional costs incurred by a facility. Incremental costs to

a facility exceeding the rate for services provided are excluded from the computation of payments. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits and will be reported separately. Special rates are determined on an individual basis, must be prior authorized by the Department, and may be used in one (1) of the following circumstances: (7-1-25)T

01. New Admissions to a Community ICF/IID. (7-1-25)T

02. Significant Change in Condition. Residents of a community ICF/IID experiencing a significant change in condition not reflected in their current rate. (7-1-25)T

03. Altered Services. A facility altered services to achieve or maintain compliance with state or federal requirements resulting in additional costs not reflected in their current rate. (7-1-25)T

04. Emergency. An emergency exists when a facility must incur additional behavioral or medical costs to prevent more restrictive placements. (7-1-25)T

526. – 529. (RESERVED)

**SUB AREA: HOME AND COMMUNITY-BASED SERVICES (HCBS)
(Sections 530-539)**

530. HCBS.
Services and supports to assist eligible participants to remain in their home and community. Federal HCBS requirements and adherence to the person-centered service plan implementation apply to Medicaid providers, where applicable. HCBS includes: (7-1-25)T

01. A&D Waiver Services. (7-1-25)T

02. Consumer-Directed Services. (7-1-25)T

03. DD 1915i and Waiver Services. (7-1-25)T

04. PCS. (7-1-25)T

05. Youth Empowerment Services (YES) for Children with Serious Emotional Disturbance (SED). (7-1-25)T

531. HCBS EXCEPTIONS.
These rules do not supersede decision-making authority legally assigned on the participant's behalf including: (7-1-25)T

01. Payees appointed by the SSA. (7-1-25)T

02. Judicial Restrictions. Court-imposed restrictions due to probation, parole, or for commitments to the Department Director; and (7-1-25)T

03. Legal Guardians. It is presumed that the parents of participants birth through seventeen (17) years of age have full decision-making authority unless a minor child has another legally assigned decision-making authority. (7-1-25)T

532. (RESERVED)

533. HCBS: PROVIDER QUALIFICATIONS AND DUTIES.
Providers must develop and implement policies and procedures to address the HCBS setting requirements. (7-1-25)T

534. (RESERVED)

535. EXCEPTIONS TO RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
Exceptions to residential setting requirements must be based on a participant's needs identified through person-centered planning. Service plans with exceptions must be submitted to the Department or its designee for review and approval. (7-1-25)T

536. HCBS PERSON-CENTERED PLAN REQUIREMENTS.
In addition to federal requirements, legal guardians without full decision-making authority hold a participatory role as identified by the participant. (7-1-25)T

01. Setting Selection. Identify and document the alternative HCBS options considered by the participant, or the participant's decision-making authority. (7-1-25)T

02. Plan Signatures. The plan must also be signed by the plan developer and all individuals and providers responsible for its implementation. (7-1-25)T

03. Residential Requirements. Any exception to residential provider-owned or controlled setting qualities must be documented in the person-centered plan. (7-1-25)T

537. – 538. (RESERVED)

539. HCBS: PARTICIPANT ELIGIBILITY.

01. Federal and State Eligibility Requirements. To be enrolled in an HCBS waiver or State Plan option program, a participant must meet the following eligibility requirements: (7-1-25)T

a. An independent assessment; (7-1-25)T

b. A state-approved person-centered plan; (7-1-25)T

c. Annual eligibility redetermination; and (7-1-25)T

d. Other state-established criteria for determining Medicaid eligibility. (7-1-25)T

02. Failure to Meet Requirements. A participant who does not meet eligibility criteria is subject to termination of enrollment. (7-1-25)T

03. Conditions for Termination. The Department will terminate participant enrollment if they: (7-1-25)T

a. Do not have an identified need for a waiver or State Plan option service; (7-1-25)T

b. Elect not to use services offered under the HCBS waiver or State Plan option; (7-1-25)T

c. Decline to engage in person-centered planning; (7-1-25)T

d. Do not meet other HCBS eligibility requirements; or (7-1-25)T

e. Are non-responsive to three or more contact attempts by the Department or its designee. (7-1-25)T

04. Continuous Eligibility for Children Under Age Nineteen. Continuous health care assistance eligibility for children under age nineteen (19), as provided in IDAPA 16.03.01, does not apply for a participant under the age of nineteen (19) who is enrolled in an HCBS waiver or State Plan option program or who has accessed Medicaid coverage through an HCBS waiver or State Plan option program. (7-1-25)T

SUB AREA: AGED AND DISABLED (A&D) WAIVER SERVICES
(Sections 540-548)

540. A&D WAIVER SERVICES: DEFINITIONS.

01. A&D Waiver Services. Services for the elderly and physically disabled to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like or community-based setting. It does not include participants in skilled, or intermediate care facilities, nursing facilities, ICF/IID or hospitals. When possible, services should be available in the participant's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports. (7-1-25)T

02. Employer of Record. An entity that bills for services, withholds required taxes, and conducts other administrative activities for a waiver participant. Such an entity is also called a PAA functioning as a fiscal intermediary (FI). (7-1-25)T

03. Employer of Fact. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver provider. This individual may be a family member. (7-1-25)T

541. A&D WAIVER SERVICES: ELIGIBILITY.

The number of Medicaid participants to receive waiver services under the A&D HCBS waiver is limited to the projected number of users identified in the Department's approved waiver. Participants who apply for waiver services after the waiver maximum is reached are placed on a waiting list and will have their applications processed after the new waiver year begins. The earliest waiver approval date for these participants is the first date of a new waiver year. Participants are eligible when they meet the following criteria: (7-1-25)T

01. Age. Are eighteen (18) years of age or older. (7-1-25)T

02. Disabling Condition. Have a disabling condition that impairs their mental or physical function or independence; (7-1-25)T

03. Non-Institutional Setting. Can be maintained safely and effectively in a non-institutional setting; (7-1-25)T

04. Require Services. In the absence of such services, require the level of care provided in a NF; (7-1-25)T

05. Average Daily Cost. Cannot exceed the participant's waiver and other medical services for the average daily cost of NF care; (7-1-25)T

06. Non-Use. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program unless services were inaccessible; and (7-1-25)T

07. Admission to a NF. A participant determined by the Department to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a NF. (7-1-25)T

08. NF Level of Care, Adults. Based on assessment results, the level of impairment of an individual is established by the Department. (7-1-25)T

542. A&D WAIVER SERVICES: COVERAGE AND LIMITATIONS.

Waiver services are provided to prevent institutional placement, provide for the greatest degree of independence possible, enhance quality of life, encourage individual choice, and achieve and maintain community integration. (7-1-25)T

01. Adult Day Health. Supervised, structured services provided outside the participant's home in a non-institutional, community-based setting, and encompassing health and social services, recreation, supervision for safety, and assistance with ADL needed to ensure optimal function of the participant. Services do not include room and board payments. (7-1-25)T

02. Adult Residential Care. A range of services provided in a homelike, noninstitutional setting that

includes licensed Residential Assisted Living Facilities and CFHs. Administrative oversight must be provided for all services provided or available in these settings. Payment does not include room and board. The number of residents in a setting is limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. Services are provided in a congregate setting and include: (7-1-25)T

a. Medication assistance, to the extent permitted under State law; (7-1-25)T

b. Assistance with ADL; (7-1-25)T

c. Meals, including special diets; (7-1-25)T

d. Housekeeping; (7-1-25)T

e. Laundry; (7-1-25)T

f. Transportation; (7-1-25)T

g. Opportunities for socialization for participants in a RALF; (7-1-25)T

h. Recreation; and (7-1-25)T

i. Assistance with personal finances. (7-1-25)T

03. Specialized Medical Equipment and Supplies. (7-1-25)T

a. Devices, controls, or appliances enabling a participant to increase their abilities to perform ADL, or to perceive, control, or communicate with the environment in which they live; and (7-1-25)T

b. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and DME and non-DME not available under State Plan or EPSDT. (7-1-25)T

04. Non-Medical Transportation (NMT). Transportation enabling a participant to access waiver and other community services and resources. Whenever possible, non-paid supports or public transit providers are used. (7-1-25)T

05. Attendant Care. Services involving tasks dealing with the functional needs of the participant and accommodating their needs for long-term maintenance, supportive care, or ADL. These services include personal assistance and medical tasks that can be done by unlicensed persons or delegated to an unlicensed person by a licensed health care professional or the participant. Services are based on a participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. Assistance may be hands-on assistance or prompts to perform a task. (7-1-25)T

06. Chore Services. Include intermittent assistance or chore activities when necessary to maintain functional use of the participant's home or to provide a clean, sanitary, and safe environment. Services are only available when neither the participant, nor anyone else in the home, is capable of performing or financially providing for them, and when no other non-paid support, landlord, agency, or third-party payer is willing or able to provide. Services are limited to those provided in a home rented or owned by the participant. For rental property, the Department examines the lease agreement for landlord responsibilities prior to any authorization of service. (7-1-25)T

07. Companion Services. In-home services that include non-medical care, supervision, and socialization provided to a functionally impaired adult ensuring the safety and well-being of a person who cannot be left alone due to their condition. The provider may live with a participant. The provider may provide cuing and occasional assistance ADL and perform light housekeeping tasks that are incidental to the care and supervision of the participant, but the primary responsibility is to provide companionship and be accessible in case of emergency. (7-1-25)T

08. Consultation (Self-Direction). Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family by consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver. (7-1-25)T

09. Home-Delivered Meals. Meals delivered to the participant's home that promote adequate nutrition. Participants can receive one (1) to two (2) meals per day when they rent or own a home, are alone for extended periods with no caregiver, and are unable to prepare a meal without assistance. (7-1-25)T

10. Homemaker Services. Performing for or assisting the participant with essential errands and other routine housekeeping duties when no one else in the household is capable of performing these tasks. (7-1-25)T

11. Environmental Accessibility Adaptations. Minor housing adaptations necessary for a participant to function with greater independence in their home, or without which, would require institutionalization or pose a risk to health, or safety including: (7-1-25)T

a. Installations or modifications necessary to accommodate medical equipment and supplies necessary for the health and safety of the participant but excludes those that are not of direct medical or remedial benefit to the participant. (7-1-25)T

b. Unless otherwise authorized, permanent modifications are limited to the participant's principal residence that is owned by the participant or their non-paid family. (7-1-25)T

c. Portable or non-stationary modifications may be made when a participant or their non-paid family rents a home, and modifications follow a participant to their next residence. (7-1-25)T

12. Personal Emergency Response System (PERS). Electronic devices enabling participants to secure help in an emergency which connects to a participant's phone and is programmed to signal a response center when activated. The response center is staffed by trained professionals. PERS is limited to participants who rent or own a home, or live with unpaid caregivers, are alone for extended periods with no caregiver, and require extensive, routine supervision. (7-1-25)T

13. Respite Care. Short-term breaks from caregiving responsibilities to non-paid caregivers. The caregiver or participant selects, trains, and directs the provider. While receiving respite care, participants cannot receive other duplicative services. Respite care does not include room and board payments. Services may be provided in a participant's residence, CFH, DDA, RALF, or ADH facility. (7-1-25)T

14. Skilled Nursing. Intermittent or continuous oversight, training, or skilled care within the scope of the Nurse Practice Act provided by an RN or LPN under the supervision of an RN. Services cannot be less cost-effective than a Home Health visit. (7-1-25)T

15. Residential Habilitation. Habilitation services to help an individual acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity, and includes training in one of the following: (7-1-25)T

a. Self-direction; (7-1-25)T

b. Money management; (7-1-25)T

c. Daily living skills; (7-1-25)T

d. Socialization not including participation in non-therapeutic activities that are diversional or recreational in nature; (7-1-25)T

e. Mobility; (7-1-25)T

f. Behavior shaping and management. (7-1-25)T

g. Personal assistance services that assist an individual in ADL, household tasks, and other routine activities as the participant or their primary caregivers are unable to accomplish on their own behalf. (7-1-25)T

h. Skills training to teach participants and supports to perform activities with greater independence and to reinforce habilitation training. (7-1-25)T

16. Day Habilitation. Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting. Services focus on enabling the participant to attain or maintain their maximum functional level and are coordinated with any physical, occupational, or speech-language therapy services listed in the plan of care. Services may reinforce skills taught in school, therapy, or other settings. (7-1-25)T

17. Supported Employment. Competitive work in integrated work settings for individuals for whom competitive employment has not traditionally occurred, or when competitive employment is interrupted or intermittent due to severe disability. The nature and severity of an individual's disability requires intensive supported employment services or extended services for them to work. This service is not available when funded under another program. (7-1-25)T

18. Transition Services. Goods and services enabling a participant residing in a NF, hospital, IMD, or ICF/IID to transition to a community-based setting immediately following discharge from a qualified institution after a minimum of forty-five (45) days. (7-1-25)T

a. Services may include: (7-1-25)T

i. Security deposits required to obtain a lease on an apartment or home; (7-1-25)T

ii. Cost of essential household furnishings; (7-1-25)T

iii. Set-up fees or deposits for utility or service access; (7-1-25)T

iv. Services necessary for health and safety prior to occupancy; (7-1-25)T

v. Moving expenses; and (7-1-25)T

vi. Activities to assess need, arrange for, and procure transition services. (7-1-25)T

b. Exclusions. Ongoing expenses (including utilities), real property, décor, or entertainment and recreational items. (7-1-25)T

c. Limitations. A total cost of two thousand dollars ($2,000) per participant and only accessed every two (2) years, following a qualifying transition. Services are furnished when a participant is unable to meet an expense or when a support cannot be obtained from other sources. (7-1-25)T

19. A&D Case Management. To assist participants with gaining and coordinating access to necessary care and services appropriate to the needs of the individual. (7-1-25)T

543. A&D WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Individual Service Plan. The Department administers the assessment and develops the initial individual service plan. The Department reviews and approves all individual service plans based on information from the assessment and any other medical information that verifies the need for services, and authorizes services by type, scope, and amount. All individual service plans must meet HCBS person-centered planning requirements. (7-1-25)T

a. Services not in the individual service plan or exceeding those approved by the Department are not

eligible for Medicaid payment. (7-1-25)T

b. The earliest services can be approved is on the date an individual service plan is signed by the participant or their designee. (7-1-25)T

c. All services that are provided must be based on a documented service plan. (7-1-25)T

d. A new plan must be developed and approved annually. (7-1-25)T

e. The plan may be adjusted during the year with an addendum. These adjustments must be based on changes in participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment is subject to Department PA. (7-1-25)T

02. Provider Records. (7-1-25)T

a. Providers must document each visit made or service provided to the participant, and record the following: (7-1-25)T

i. Service date; (7-1-25)T

ii. Services provided; (7-1-25)T

iii. Statement of participant's response to services when applicable, including any changes in their condition; and (7-1-25)T

iv. Length of visit, including time in and out. Unless the Department determines a participant is unable to, service delivery is verified by the participant by signing a service record. (7-1-25)T

b. Providers must maintain service delivery records accessible to participants. (7-1-25)T

c. The individual service plan must be available to all providers and the Department. The individual service plan and assessment are available from the Department for providers with a release of information signed by the participant or legal representative. (7-1-25)T

d. EVV Systems do not replace documentation requirements but may be used to generate documentation. (7-1-25)T

03. Provider Notification. Providers must document in the service record and notify the Department, medical provider, case manager, and family when any significant changes in the participant's condition are noted. (7-1-25)T

544. A&D WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of an agency. The Department may enter into provider agreements with individuals in situations when no agency exists, or no FI is willing to provide services. Such agreements are reviewed annually to verify whether coverage by a PAA or FI is still not available. (7-1-25)T

02. Fiscal Intermediary Services (FI). An FI providing Consultation services supporting self-direction must: (7-1-25)T

a. Assure compliance with legal requirements related to employment of providers; (7-1-25)T

b. Offer supportive services to enable participants or their families to perform the required employer tasks themselves; (7-1-25)T

c. Bill Medicaid for services authorized by the Department; (7-1-25)T

d. Collect any participant participation due; (7-1-25)T

e. Pay providers for service; (7-1-25)T

f. Perform all necessary withholding as required by state and federal regulations; (7-1-25)T

g. Assure that providers meet the required standards and qualifications; (7-1-25)T

h. Maintain liability insurance coverage; (7-1-25)T

i. Conduct annual participant satisfaction or quality control reviews made available to the Department and the public; and (7-1-25)T

j. Obtain required background checks and health screens on employees. (7-1-25)T

03. Provider Qualifications. Providers of homemaker, respite care, ADH, transportation, chore services, companion services, attendant care, adult residential care, A&D Case Management, and home-delivered meals 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 or activities in the Department's A&D waiver as approved by CMS. Direct care workers cannot be a participant's spouse. (7-1-25)T

04. Quality Assurance (QA). Providers must respond to QA reviews within forty-five (45) days of receiving results. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (7-1-25)T

05. Specialized Medical Equipment and Supplies. Must be enrolled with Medicaid as a supplier. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference is given to the most cost-effective option to meet a participant's needs. (7-1-25)T

06. Consultation Services. Must be provided through a PAA by a person with demonstrated skills in training participants/family members to hire, fire, train, and supervise their own care providers. (7-1-25)T

07. Adult Residential Care. Must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. (7-1-25)T

08. Home-Delivered Meals. (7-1-25)T

a. Each meal meets one third (1/3) of the Recommended Daily Allowance, as defined by the United States Department of Agriculture (USDA); (7-1-25)T

b. Meals are delivered under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (7-1-25)T

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; and (7-1-25)T

d. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. (7-1-25)T

09. PERS. Must demonstrate that devices installed in a participant's home meet Federal Communications Commission (FCC) standards. (7-1-25)T

10. Adult Day Health. (7-1-25)T

a. Providers must notify the Department for the participant when the service is provided in a CFH other than the participant's primary residence. (7-1-25)T

b. Providers must be free from communicable disease. (7-1-25)T

11. Non-Medical Transportation. Possess a valid driver's license and vehicle insurance. (7-1-25)T

12. Attendant Care. Must be employees of an agency. (7-1-25)T

13. Homemaker Services. Must be employees of an agency. (7-1-25)T

14. Environmental Accessibility Adaptations. Must meet applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (7-1-25)T

15. Residential Habilitation. Employment by a certified residential habilitation agency. Prior to delivering services, complete an orientation program and additional training requirements must be completed within six (6) months of employment. (7-1-25)T

16. Day Habilitation. Employed by a certified residential habilitation agency. Prior to delivering services, staff must complete an orientation program and complete additional training within six (6) months of employment. (7-1-25)T

17. Respite Care. Receive instructions in the participant's needs, demonstrate the ability to follow the service plan, and be free of communicable disease. (7-1-25)T

18. Supported Employment. Provided by an agency that meets State requirements. (7-1-25)T

19. Chore Services. Be skilled in the service to be provided; and demonstrate the ability to follow a service plan. (7-1-25)T

20. Transition Services. Transition managers. (7-1-25)T

21. A&D Case Management. Case Managers must be employed by an agency that is not an FI. Case Managers may not provide other services. (7-1-25)T

545. A&D WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. Rates. Reimbursement for services include both services and mileage. Mileage for provider transportation to and from the service delivery location is not reimbursable. (7-1-25)T

02. Electronic Visit Verification (EVV) Compliance. Claims for Attendant Care, Homemaker, and Respite services require EVV compliance to be reimbursable. (7-1-25)T

546. – 548. (RESERVED)

**SUB AREA: TRANSITION MANAGEMENT
(Section 549)**

549. TRANSITION MANAGEMENT.
Provides relocation assistance and intensive service coordination activities to assist NF, hospital, IMD, and ICF/IID residents to transition to community settings of their choice. Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community, functioning as a liaison between the participant, institutional or facility discharge staff, and other individuals identified by the participant. Participants are eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) days. (7-1-25)T

01. Provider Qualifications. Transition managers must: (7-1-25)T

a. Successfully complete of a Department-approved Transition Manager training prior to providing

any transition management or transition services; (7-1-25)T

b. Have a Bachelor's degree in a human services field or three (3) years' supervised work experience with the population served; and (7-1-25)T

c. Be employed by an agency. (7-1-25)T

02. Service Description. Includes the following activities: (7-1-25)T

a. A comprehensive assessment of health, social, and housing needs; (7-1-25)T

b. Development of housing options, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; (7-1-25)T

c. Assistance with tasks necessary to accomplish a move from the institutional setting; (7-1-25)T

d. Securing Transition Services to coordinate the move, including: (7-1-25)T

i. Obtaining DME, assistive technology, and medical supplies; (7-1-25)T

ii. Arranging for home modifications; (7-1-25)T

iii. Applying for public assistance; or (7-1-25)T

iv. Arranging household preparations including scheduling moving or cleaning services, utility set-up, purchasing furniture, and household supplies. (7-1-25)T

e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; and (7-1-25)T

f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, post-secondary educational institutions and proprietary schools, and community inclusion. (7-1-25)T

03. Limitations. Transition management is limited to seventy-two (72) hours per participant per qualifying transition. (7-1-25)T

SUB AREA: PERSONAL CARE SERVICES (PCS)
(Sections 550-559)

550. PCS: DEFINITIONS.

01. PCS. Medically oriented care services for a participant's physical or functional requirements in the participant's home or personal residence but does not include housekeeping or skilled nursing care. (7-1-25)T

02. PCS Family Alternate Care Home. A private home licensed by the Department to provide PCS to one (1) or two (2) children, who are unable to reside in their own home and require medically oriented tasks related to the child's physical or functional needs. (7-1-25)T

551. PCS: ELIGIBILITY.

01. Level of Care. The Department conducts an assessment to determine whether a participant's medical condition impairs their physical or mental functions or independence, and whether they can remain safely and effectively in their personal residence when supported by authorized PCS. (7-1-25)T

02. Redetermination. Required annually to reauthorize PCS or to refer a participant to a NF. (7-1-25)T

03. Significant Changes. An assessment can be requested due to changes in a participant's needs at any time. (7-1-25)T

552. PCS: COVERAGE AND LIMITATIONS.

01. Medical Care and Services. Tasks related to a participant's physical or functional requirements provided in the participant's personal residence including assistance with: (7-1-25)T

a. Basic personal care and grooming; (7-1-25)T

b. Bladder or bowel routines or requirements; (7-1-25)T

c. Food, nutrition, and diet activities; (7-1-25)T

d. Continuation of at home active treatment programs to increase or maintain independence for participants with DD; (7-1-25)T

e. Physician-ordered medications ordinarily self-administered; (7-1-25)T

f. Non-nasogastric gastrostomy tube feedings that meet the following requirements: (7-1-25)T

i. Non-complex tasks that can be safely performed in a participant's location; (7-1-25)T

ii. An RN assessed a participant's needs and developed a written procedure according to a participant's individualized needs; (7-1-25)T

iii. An RN delegates by name who can perform this procedure only after an individual demonstrates safe performance of the individualized procedure. RNs must document the strengths and weaknesses of any delegates, and evaluate their performance monthly; (7-1-25)T

iv. Delegates must report any change in participant status or problems with the procedure immediately to the RN; (7-1-25)T

v. The supervisor RN maintains documentation of the individualized procedure, the supervised performance of the procedure, and follow-up evaluations of delegates readily available for review, in the participant's record; and (7-1-25)T

vi. Direct care workers only give routine medication through a non-nasogastric tube as authorized by a supervisor RN. (7-1-25)T

02. Non-Medical Care and Services. Includes the following tasks, when no natural supports are available: (7-1-25)T

a. Minimal housekeeping tasks incidental to the delivery of an ADL care task essential to participant comfort or health and excludes services for any other residents. (7-1-25)T

b. Accompanying a participant to medical appointments or other trips reasonably required for medical diagnosis or treatment. (7-1-25)T

c. Shopping for food or other items specific to a participant's health and maintenance. (7-1-25)T

03. Place of Service. PCS may be provided in a participant's personal residence, including a CFH, a RALF, or a PCS Family Alternate Care Home (FACH), and in the community only when an individual's daily activities take them out of the home and are limited to tasks in their approved service plan. (7-1-25)T

04. Service Exclusions. (7-1-25)T

a. Irrigating or suctioning any body cavity requiring sterile procedures or applying dressings with prescription medication or aseptic techniques; (7-1-25)T

b. Catheter insertion or sterile irrigation; (7-1-25)T

c. Injecting fluids into veins, muscles or skin; and (7-1-25)T

d. Administering medication not authorized by a supervisor RN. (7-1-25)T

05. Participant Limitations. Sixteen (16) hours per week unless authorized under EPSDT. (7-1-25)T

06. Provider Limitations. No home, regardless of the number of providers in a home, may serve more than two (2) children authorized for eight (8) or more hours of PCS per day. (7-1-25)T

553. PCS: PROCEDURAL REQUIREMENTS.

01. Service Plan. All PCS are provided based on a documented service plan according to place of service. (7-1-25)T

a. PAAs prepare the service plan with participants in their own home or a PCS FACH, based on applicable physician or authorized provider information, assessment results (including any, QIDP assessments or observations), and participant provided information. Service plans must include all medical and non-medical tasks the provider performs, including amount, type, and frequency. Plans must be updated annually or based on treatment results or significant changes in participant needs. (7-1-25)T

b. CFH/RALF service plans must meet applicable licensing requirements for each residence type. (7-1-25)T

02. Supervision. An RN or QIDP provides oversight of PCS as required by the Department. Activities include: (7-1-25)T

a. Service plan development assistance, including in-home active treatment plans. (7-1-25)T

b. Review of treatment provided and verified by service delivery records and through on-site participant interviews. (7-1-25)T

c. Service plan re-evaluations, including on-site visits to evaluate change in a participant's condition as needed. (7-1-25)T

d. Immediate notification to any guardian, emergency contact, or family member when a significant change in a participant's physical condition or response to services occurs. (7-1-25)T

03. PA. Authorizations are based on the participant's assessment, individual service plan, and any other medical information supporting medical needs. (7-1-25)T

04. Record Requirements in Participant Homes. PCS records must be maintained for all participants in their own homes or in a PCS (FACH), in a format accessible to the participant. (7-1-25)T

a. Providers must document every visit made to a participant's home and record the date, time, duration, services provided, and any changes noted in a participant's condition or deviations from the service plan. (7-1-25)T

b. Participants or legal guardians must verify service delivery by signing the record. (7-1-25)T

c. Providers must sign the service plan indicating they will deliver services according to the authorization and consistent with HCBS requirements. (7-1-25)T

d. EVV systems described do not replace documentation requirements but may be used to generate documentation. (7-1-25)T

05. Provider Notification. Providers must notify the Department and the medical provider for any significant changes in a participant's condition occur, and document in the participant record. (7-1-25)T

554. PCS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Direct Care Workers. All providers must be an RN, an LPN, or meet personal assistant standards. All staff must receive training for service quality. The Department may require a CNA for personal assistance when a participant's medical condition warrants. (7-1-25)T

02. Training for Participants with DD. When services provided in a participant's home require more than physical assistance, providers must complete a Department-approved DD training course or have experience providing direct services to people with DD unless the provider qualifies as a QIDP. The Department may temporarily approve staff meeting all qualifications except for the required training course or experience, when the Department verifies: (7-1-25)T

a. No other qualified providers are available; (7-1-25)T

b. The direct care worker is enrolled in the next available training course with a graduation date no more than six (6) months from the request for temporary provider status; and (7-1-25)T

c. A supervising QIDP provides monthly oversight visits until the direct care worker graduates from the training program. (7-1-25)T

03. Children's PCS Delivered in a Provider's Home. Providers must be licensed or certified as a child foster care or PCS FACH. (7-1-25)T

04. Health Screen. Direct Care staff must complete a health questionnaire, kept in their personnel files. If they have a medical issue, a statement from a medical provider must verify they are able to perform all required duties. Misrepresentation of information is cause for termination of employment and disqualifies an employee from providing Medicaid services. (7-1-25)T

05. Personal Assistance Agency (PAA) and Fiscal Intermediaries. (7-1-25)T

a. Recruit, hire, fire, train, supervise, schedule, process payroll, and ensure all direct care staff are qualified to provide quality services; (7-1-25)T

b. Maintain liability insurance coverage; (7-1-25)T

c. Ensure staffing of an RN or, when applicable, a QIDP supervisor to develop and complete service plans and provide supervision of service delivery; (7-1-25)T

d. Assign qualified staff to participants honoring their choices; and (7-1-25)T

e. Conduct annual participant satisfaction or quality control reviews available to the Department and the public. (7-1-25)T

555. PCS: REIMBURSEMENT.

01. Calculated Fee. Fees include a basic rate for PCS and mileage. No separate charges are paid for provider transportation to and from a participant's home or non-medical transportation, unless authorized by the Department under another billable service. (7-1-25)T

02. Rate Methodology. Rates are calculated using an annual survey of all Idaho NFs and ICFs/IID to

establish the WAHR for Idaho NF employees in comparable positions. (7-1-25)T

03. PAA Rates. The Department establishes PAA rates for PCS based on the WAHR multiplied by a supplemental component composed of costs reported for travel, administration, training, and all payroll taxes and fringe benefits collected during the most recent State Fiscal Year. (7-1-25)T

04. CFH and RALF Rates. PCS rates for residents are paid based on their assessed care level as follows: (7-1-25)T

a. Level I, any diagnosis EXCEPT Serious and Persistent Mental Illness (SPMI), DD, Alzheimer's Disease and Related Dementias (ADRD) = one and twenty-five hundredths (1.25) hrs/day. (7-1-25)T

b. Level II, any diagnosis EXCEPT SPMI, DD, ADRD = one and five tenths (1.5) hrs/day. (7-1-25)T

c. Level III, any diagnosis = two and twenty-five hundredths (2.25) hrs/day. (7-1-25)T

d. Level IV, ONLY SPMI, DD, ADRD who scores at level one (1) or two (2) = one and seventy-nine hundredths (1.79) hrs/day. (7-1-25)T

05. Supervisor RN and QIDP Rates. The Department authorizes oversight activities paid per visit to conduct participant evaluations and for Service Plan development and may authorize additional evaluations or emergency visits as needed. (7-1-25)T

556. PCS: QUALITY IMPROVEMENT (QI).
Providers must respond within forty-five (45) days of receiving results of a Department review. Providers must implement a QI plan for identified problems and provide results upon request. (7-1-25)T

557. – 559. (RESERVED)

**SUB PART: ENHANCED DD SERVICES
(Sections 560-579)**

560. DD SERVICES: REQUIREMENTS.
DD services, including Family-Directed Community Supports (FDCS), are covered when provided with the right care, in the right place, at the right price, and with the right outcomes to enhance health and safety, and promote participants' rights, self-determination, and independence. Services require an assessment of the need for services, development of a service plan with the budget assigned by the Department, PA of services, and a quality improvement program. (7-1-25)T

01. Right Care. Standard of care for the diagnosis, functional needs, and abilities to achieve the desired outcome. (7-1-25)T

02. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-25)T

03. Right Price. The most integrated and least expensive services that are sufficient to address the participant's needs as identified in the assessment. (7-1-25)T

04. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-25)T

561. DD DETERMINATION STANDARDS: PARTICIPANT ELIGIBILITY.
Assessments required for determining eligibility are completed prior to the participant receiving services and include documentation of a DD, an MSDA, and a functional assessment. For adult DD waiver services, an assessor must determine the participant meets ICF/IID level of care. DD as under Section 66-402, Idaho Code, is a chronic disability that appears before the age of twenty-two (22) years evidenced by: (7-1-25)T

01. **Impairment**. Impairment is attributed to one (1) of the following: (7-1-25)T

a. Intellectual Disability. (7-1-25)T

i. IQ test score of seventy (70) or below with a five (5) point standard error of measurement; or (7-1-25)T

ii. A delay of thirty percent (30%) overall on a functional assessment when under the age of five (5). (7-1-25)T

b. Cerebral Palsy. (7-1-25)T

c. Epilepsy, except when seizure-free and not on medication for three (3) years. (7-1-25)T

d. Autism with pervasive developmental disorder. (7-1-25)T

e. Other conditions closely related or similar to a-d. requiring similar treatment or services: (7-1-25)T

i. IQ test score above seventy-five (75) when functional limitations create a condition like intellectual disability. (7-1-25)T

ii. Disruption in motor function like cerebral palsy. (7-1-25)T

iii. Disorder causing interruption of consciousness like epilepsy. (7-1-25)T

iv. Not a mental illness. (7-1-25)T

f. Dyslexia resulting from a-e. (7-1-25)T

02. **Substantial Functional Limitations**. The impairment requires a combination and sequence of services that need to be individually planned and coordinated for substantial functional limitations within three (3) major life activities in b-h. (7-1-25)T

a. Substantial functional limitations are demonstrated by having a score of two (2) standard deviations below the mean. Participants under three (3) years of age can alternatively by: (7-1-25)T

i. Scoring thirty percent (30%) below age norm; or (7-1-25)T

ii. Exhibiting a six (6) month delay. (7-1-25)T

b. Self-care. (7-1-25)T

i. Under Age twenty-one (21): Manifested when age-appropriate skills are limited, and substantial assistance is required. (7-1-25)T

ii. Age twenty-one (21) and Over: Manifested when the person requires assistance in performing eating, hygiene, grooming, or health care skills, or the time to complete these tasks causes substantial impairment of conducting other ADL or retaining employment. (7-1-25)T

c. Receptive and expressive language. (7-1-25)T

i. Under Age three (3): Manifested when they have been diagnosed with performance thirty percent (30%) below age norm (adjusted for prematurity up to two (2) years) or demonstrated at least two (2) standard deviations below the mean in either area or one-and-one half (1 1/2) below in both areas of language development. (7-1-25)T

ii. Age three (3) and Above: Manifest when a person is unable to communicate effectively without the

aid of a third person, a person with special skills, or without an assistive device (such as sign language). (7-1-25)T

d. Learning manifested when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that interventions beyond normal are required for the development of social, self-care, language, academic, or vocational skills. (7-1-25)T

e. Mobility. (7-1-25)T

i. Under Age twenty-one (21): Measured by an age-appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with skills expected of children of the same age. (7-1-25)T

ii. Age twenty-one (21) and Over: Manifested when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. (7-1-25)T

f. Self-direction. (7-1-25)T

i. Under Age twenty-one (21): Manifested when the child is unable to help themselves or cooperate with others with age-appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments. (7-1-25)T

ii. Age twenty-one (21) and Over: Manifested when assistance is required in managing personal finances, protecting self-interest, or making decisions that may affect well-being. (7-1-25)T

g. Capacity for independent living. (7-1-25)T

i. Under Age twenty-one (21): Measured by an age-appropriate instrument that compares personal independence and social responsibility expected of comparable age and cultural groups. (7-1-25)T

ii. Age twenty-one (21) and Over: A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. (7-1-25)T

h. Economic self-sufficiency. (7-1-25)T

i. Under Age five (5): Evidenced by eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). (7-1-25)T

ii. Age five (5) to Age Twenty-one (21): Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. (7-1-25)T

iii. Age twenty-one (21) and Over: Manifested when unable to perform the tasks necessary for regular employment or limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. (7-1-25)T

03. Necessity of Care. The need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated. (7-1-25)T

a. Under Age five (5): Determined by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP. (7-1-25)T

b. Age five (5) and Over: Life-long or extended duration means the condition has reasonable likelihood of continuing for a protracted period, including continuation throughout life. (7-1-25)T

562. (RESERVED)

563. DD DETERMINATION STANDARDS: TEST INSTRUMENTS.

01. Assessments. A Department-approved tool for conducting cognitive and functional assessments is used to determine eligibility. An appropriate professional must verify tests over one (1) year old reflect the individual's status. (7-1-25)T

02. Children's Test Instruments. Evaluations must be performed by qualified personnel with experience and expertise with children using age-appropriate evaluation tools and practices, considering the child's language and motor skills. (7-1-25)T

564. DD SERVICES: QUALITY IMPROVEMENT.

01. Quality Improvement (QI). Audit findings may lead to quality improvement (QI) activities, which consist of the Department and providers working to resolve identified issues and enhance services provided including consultation, technical assistance, and recommendations. If deficiencies are not resolved, corrective action occurs. (7-1-25)T

02. Corrective Action. A formal process to address significant or unresolved deficiencies identified during the review process that includes issuance of a corrective action plan, reporting to Medicaid Program Integrity Unit, or termination of a provider agreement. (7-1-25)T

03. Abuse, Fraud, or Substandard Care. Suspected abuse, fraud, or substandard care is referred to the Department and other applicable agencies. (7-1-25)T

565. (RESERVED)

566. DD SERVICES: ADMINISTRATIVE APPEALS.
Applicants and participants may file an administrative appeal if they disagree with Department decisions affecting individual rights, including eligibility determinations, assessment results, budget assignments, exception reviews, and authorization of services or service plans. (7-1-25)T

567. (RESERVED)

568. ADULT DD SERVICES: DEFINITIONS.

01. Clinical Review. Process of professional review to validate the need for continued services. (7-1-25)T

02. Exception Review. Clinical review of a plan falling outside established standards due to a health or safety risk. (7-1-25)T

03. Health. The prevention of deterioration of one's physical or mental health condition, cognitive functioning, or an increase in maladaptive behavior, and is related to the effects of one's disability. (7-1-25)T

04. Health Risks. Must be established through written documentation and current treatment recommendations from a licensed practitioner of the healing arts under these rules, or other professional licensed by the State of Idaho whose recommendation is within the scope of their license. Such documentation must establish: (7-1-25)T

a. The current physical or mental condition, or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and (7-1-25)T

b. The specific supports or services being requested, including type and frequency if applicable, that will address the identified need. (7-1-25)T

c. To comply with the documentation requirement, the Department may require the participant to obtain additional consultation or assessment, available to the participant and covered by Medicaid, from a professional licensed by the State of Idaho acting within the scope of their license. If the Department requires additional consultation or assessment, the Department will specify the nature of the consultation or assessment and the necessary documentation. (7-1-25)T

05. Safety. Prevention of criminal activity, destruction of property, or injury or harm to self or others. (7-1-25)T

06. Safety Risks. Must be documented by the following: (7-1-25)T

a. Current incident reports; (7-1-25)T

b. Police reports; (7-1-25)T

c. Assessments from a licensed practitioner of the healing arts under these rules or a professional licensed in Idaho and whose assessment is within the scope of their license; or (7-1-25)T

d. Status reports and implementation plans that reflect the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s). (7-1-25)T

e. Such documentation must establish: (7-1-25)T

i. An imminent or likely safety risk; and (7-1-25)T

ii. The specific supports or services that are being requested, including the type and frequency if applicable, that are likely to prevent that risk. (7-1-25)T

569. ADULT DD SERVICES: ELIGIBILITY DETERMINATION.
Participants aged eighteen (18) or older are eligible for adult DD services when they meet DD determination standards. (7-1-25)T

570. (RESERVED)

571. ADULT DD SERVICES: COVERAGE AND LIMITATIONS.
PA is required for service coordination, DD waiver and DD state plan services. Services must be delivered under a service plan by providers selected by the participant. (7-1-25)T

572. ADULT DD SERVICES: PROCEDURAL REQUIREMENTS.
Providers must immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, and injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other required entity. (7-1-25)T

573. ADULT DD SERVICES: SERVICE PLAN REQUIREMENTS.
The service plan identifies the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and providers. The service plan must include activities to promote progress, maintain functional skills, or delay or prevent regression. Unless the participant has a guardian, who retains full decision-making authority, the participant must make decisions regarding the type and amount of services. The Department, with the participant, ensures the service plan is based on the individualized participant budget. The plan developer must distribute a copy of the service plan, in whole or part, to any other provider identified by the participant during the person-centered planning process. (7-1-25)T

01. Assessment. The assessment with a Department-approved tool for DD service eligibility is required for all participants prior to plan development and includes: (7-1-25)T

a. History and Physical. A medical provider's assessment and referral for nursing services and

developmental therapy if anticipated to be part of the service plan. A history and physical is required within the year prior to the initiation of service and updated annually, by the medical provider. (7-1-25)T

b. Medical, Social, and Developmental Assessment (MSDA). An assessment reviewed annually to assure it accurately reflects the participant's status. The current assessment must be evaluated prior to the initiation of adult DD services. Providers obtain and use this assessment documentation for adult program or service plan development. (7-1-25)T

c. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (7-1-25)T

d. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (7-1-25)T

02. Paid Plan Developer Qualifications. Providers of direct services to the participant, or the assessor, cannot be chosen to be a paid plan developer. Plan development requires an individual be employed as a service coordinator. (7-1-25)T

03. Plan Development. The plan development process must meet the HCBS person-centered planning requirements. The participant may facilitate their own person-centered planning meeting or designate a paid or non-paid plan developer. (7-1-25)T

04. No Duplication of Services. The plan developer ensures that there is no duplication of services. (7-1-25)T

05. Plan Monitoring. The planning team, including a plan monitor, must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring includes contacting providers to identify barriers to service delivery, discussing participant satisfaction with the quality and quantity of their services, and review of provider status reviews. (7-1-25)T

06. Provider Status Reviews. Providers required to develop a PIP must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual review is due fifteen (15) days after the end of the sixth month. The annual review is due thirty (30) days after plan's end. Semi-annual and annual reviews include status of supports and services to identify progress, maintenance, or delay or prevention of regression. (7-1-25)T

07. Informed Choice. Prior to plan development, the plan developer must document they provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. Planning team members must each indicate whether they believe the service plan meets the needs of the participant and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the service plan or amendment may be referred to the Department to negotiate a resolution. (7-1-25)T

08. Provider Implementation Plan (PIP). Providers must develop a PIP that complies with HCBS setting requirements and identifies specific measurable objectives that relate to goals finalized and agreed to in the participant's authorized service plan. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the service plan. (7-1-25)T

a. Exceptions. A PIP is not required for providers of: (7-1-25)T

i. Specialized medical equipment; (7-1-25)T

ii. Home-delivered meals; (7-1-25)T

iii. Environmental accessibility adaptations; (7-1-25)T

iv. Non-Medical Transportation; (7-1-25)T

v. Personal Emergency Response System; (7-1-25)T

vi. Respite care; (7-1-25)T

vii. Chore services; (7-1-25)T

viii. Community crisis support services; (7-1-25)T

ix. Adult DD service coordination; and (7-1-25)T

x. Adult Day Health. (7-1-25)T

b. Time To Complete. PIPs must be completed within fourteen (14) days of receipt of the authorized service plan, or the service start date, whichever is later. If the authorized service plan is received after the service start date, providers must support billing by documenting service delivery as agreed to by the participant and consistent with these rules. PIP revisions must be based on changes to the needs of the participant. (7-1-25)T

c. PIP changes must be included in the participant's record, stating the reason for the change, documentation of coordination with other providers, the date a change was made, and the name and title of the person making the change. (7-1-25)T

09. Addendum to the Service Plan. (7-1-25)T

a. A service plan may be adjusted during the year with an addendum, subject to Department PA. These adjustments must be based on a change to a cost, addition or increase of a service, change of provider, addition of a restrictive intervention, or addition or increase of alone time. Additional assessments or information may be clinically necessary. (7-1-25)T

b. The Department distributes a copy of the authorized addendum to providers responsible for the implementation of the plan. (7-1-25)T

c. Upon receipt of the addendum, the provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision with their title and the date signed and maintained in the participant's record. Provider signatures are completed each time an addendum is authorized. (7-1-25)T

10. Annual Service Reauthorization. A new service plan must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current service plan for personal assistance unless delayed because of participant unavailability due to extenuating circumstances. If the service plan is not submitted within the period, authorization for provider payments may be terminated. Prior to submission, the plan developer must notify the providers who appear on the service plan of the annual review date, obtain a copy of the most recent provider status review, and convene the person-centered planning team to develop a new service plan. (7-1-25)T

11. Notifications. The Department notifies participants of its decision on their service plan. Notification includes an individualized explanation and how to appeal. (7-1-25)T

574. ADULT DD SERVICES: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis based on a participant budget. (7-1-25)T

01. Individualized Budget. The Department sets an individualized budget annually for each participant and notifies them of their set budget amount as part of the eligibility process. Notification includes information on appealing the set budget amount. Individualized budgets may be re-evaluated at the participant's request when there are documented changes in their condition with medical necessity for services not reflected in the

current inventory of needs. (7-1-25)T

02. Exception Review. Service plans or addenda requesting services exceeding the assigned budget authorized by the assessor are reviewed and authorized by the Department. Requests are authorized when one (1) of the following is met: (7-1-25)T

a. Services requested on the plan or addendum are needed to assure participant health and safety or to mitigate a documented health or safety risk. (7-1-25)T

b. Supported employment is needed for the participant to obtain or maintain employment. (7-1-25)T

03. Supported Living Levels of Support. Reimbursement for supported living is based on the participant's assessed level of support need. All service plans for supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and they are less dependent on supports, they must transition to less intense supports. (7-1-25)T

a. High support is for participants who require twenty-four (24) hour per day supports and supervision. A blend of one-to-one and group staffing is allowed. Developmental therapy, ADH, and NMT are included in this daily rate. (7-1-25)T

b. Intense support is for participants who require one-on-one, twenty-four (24) hour per day supports and supervision. Requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Developmental therapy, ADH, and NMT are included in this daily rate. To qualify for intense support, participants must be evaluated to meet one of the following criteria: (7-1-25)T

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. (7-1-25)T

ii. History of predatory sexual offenses and at high risk to re-offend. (7-1-25)T

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. (7-1-25)T

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring, without which would require placement in a NF, hospital, or ICF/IID with twenty-four- (24) hour on-site nursing. (7-1-25)T

c. Hourly support is for individuals whose needs can be met with less than twenty-four (24) hour per day support. The combination of hourly supported living, developmental therapy, supported employment, and ADH cannot exceed the maximum set daily amount established by the Department, except when: (7-1-25)T

i. A participant is eligible for high support; (7-1-25)T

ii. Supported employment is included in the service plan, causing the combination to exceed the daily limit; (7-1-25)T

iii. Documentation confirming the Person-Centered Planning team explored other options including lower-cost services and supports; and (7-1-25)T

iv. A participant's health and safety needs can be met using hourly services. (7-1-25)T

575. – 579. (RESERVED)

**SUB-PART: CHILDREN'S DD HCBS STATE PLAN OPTION
(Sections 580-589)**

580. CHILDREN'S DD HCBS STATE PLAN OPTION: DEFINITIONS.
Definitions also apply to Family-Directed Community Supports (FDCS). (7-1-25)T

01. Community. Natural, integrated environments outside of the participant's home, outside of DDA center-based settings, or at school outside of school hours. (7-1-25)T

02. Family-Centered Planning Process. A participant-focused planning process facilitated by the plan developer and directed by the participant or the participant's decision-making authority to help them make informed choices about the services and supports included on the service plan. (7-1-25)T

03. Family-Centered Planning Team. A group who discusses the participant's strengths, needs, and preferences, including their safety and the safety of those around them to develop the participant's service plan. This group includes the participant, the participant's decision-making authority, plan developer, and people chosen by the participant and the family. (7-1-25)T

581. CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.
Eligibility also applies to Family-Directed Community Supports (FDCS). (7-1-25)T

01. Eligibility Determination. A participant is eligible for the children's DD HCBS state plan option from birth through age seventeen (17), when they have a DD and a demonstrated need for these services. (7-1-25)T

02. Individualized Budget Methodology. The following categories are used to determine individualized budgets for children with DD. (7-1-25)T

a. Level I. Children meeting DD criteria. (7-1-25)T

b. Level II. Children who qualify based on functional limitations when their composite full-scale standard score of less than fifty (50) or have an overall standard score up to fifty-three (53) when combined with a maladaptive behavior score of greater than one (1) to less than two (2) standard deviations from the mean. (7-1-25)T

c. Level III. Children who qualify based on functional limitations with a composite full-scale standard score less than fifty (50) with an autism spectrum disorder diagnosis. (7-1-25)T

d. Level IV. Children who qualify based on maladaptive behaviors when their maladaptive behavior score is two (2) standard deviations or greater from the mean. (7-1-25)T

03. Annual Re-Evaluation. Budgets are re-evaluated annually or at the request of the participant, the Department when there are documented changes that may support placement in a different budget category. (7-1-25)T

04. Lapse in Service. For participants re-applying for services, the assessor evaluates whether assessments are current and accurately describe the status of the participant. (7-1-25)T

582. CHILDREN'S DD HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
All children's DD HCBS are identified on a service plan developed by the family-centered planning team and must be prior authorized. (7-1-25)T

01. Respite. Supervision on an intermittent or short-term basis for unpaid caregiver relief or in response to a family emergency or crisis, provided by a DDA or an independent provider. Payment does not include room and board. Respite may be provided in a participant's home, the private home of the independent provider, a DDA, or in the community. The following limitations apply: (7-1-25)T

a. Not be provided to enable an unpaid caregiver to work. (7-1-25)T

b. Only participants living with an unpaid caregiver are eligible. (7-1-25)T

c. Cannot exceed fourteen (14) consecutive days. (7-1-25)T

d. Must not be provided at the same time as other Medicaid services except family education for an unpaid caregiver. (7-1-25)T

e. Providers must not use restraints on participants, other than physical restraints in the case of an emergency, to prevent injury to the participant or others and as documented in the participant's record. (7-1-25)T

f. When group respite is community or center-based, there must be at least one (1) qualified staff member providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio must be adjusted accordingly. (7-1-25)T

g. Independent providers cannot provide center-based respite and may only provide group respite when the provider is a relative and the service is delivered in the participant's or provider's home. (7-1-25)T

02. Community-Based Supports. Facilitates a participant's independence and integration into the community by providing an opportunity to explore their interests, practice skills learned in other therapeutic environments and learn through interactions in typical community activities. Community-based supports must: (7-1-25)T

a. Not supplant services provided in school or therapy, or the role of a primary caregiver; (7-1-25)T

b. Ensure involvement in age-appropriate activities in integrated settings; and (7-1-25)T

c. Have at least one (1) qualified staff providing direct services for up to six (6) participants when provided as group community-based supports. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff participant ratio must be adjusted accordingly. (7-1-25)T

03. Family Education. Professional assistance to caregivers to help them meet the participant's needs by providing an orientation to DDs and to educate them on generalized strategies for behavioral modification and intervention techniques specific to a participant's diagnosis and the needs identified on the service plan. Training may be provided in a group setting not exceeding five (5) families. Providers must survey the parent or legal guardian's satisfaction of services immediately following a family education session. (7-1-25)T

04. Family-Directed Community Supports (FDCS). Families of eligible participants may choose to direct an individualized budget rather than receive traditional children's DD HCBS state plan option services when the participant lives at home with their parent or legal guardian. FDCS must be delivered on a one-to-one basis as identified on the service plan and requires PA and quality assurance. (7-1-25)T

05. Limitations for State Plan and Family-Directed Community Supports (FDCS). (7-1-25)T

a. Services are limited by the participant's individualized budget amount. (7-1-25)T

b. Services offered under the Medicaid Basic Plan cannot be authorized. (7-1-25)T

c. Duplication of services cannot be provided: (7-1-25)T

i. Goals are not separate and unique to each item or service provided; or (7-1-25)T

ii. When more than one (1) service is provided at the same time, unless otherwise authorized. (7-1-25)T

583. CHILDREN'S DD HCBS STATE PLAN OPTION: SERVICE PLAN.
In collaboration with the participant, the Department ensures the participant develops one (1) service plan within their individualized participant budget. Paid plan development is provided by the Department. (7-1-25)T

01. History and Physical. Prior to the development of the service plan, the plan developer must obtain

a current history and physical completed by a medical provider annually, or earlier as determined by the medical provider. Also, required for Family-Directed Community Supports (FDCS). (7-1-25)T

02. Service Plan Development. The service plan is developed with the participant, their decision-making authority, facilitated by the Department. If the participant is unable to attend the family-centered planning meeting, the service plan must contain documentation justifying their absence. Also, required for Family-Directed Community Supports (FDCS). (7-1-25)T

03. Requirements for Collaboration. Providers must coordinate with the family-centered planning team as specified on the service plan. Also, required for Family-Directed Community Supports (FDCS). (7-1-25)T

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months. The plan monitor meets face-to-face with the participant and their decision-making authority at least annually. (7-1-25)T

05. Provider Status Reviews. Community-Based Support providers must submit six (6) month and annual provider status reviews to the plan monitor. Six-month status reviews must be submitted thirty (30) days prior to the six-month date listed on the plan. Annual provider status reviews must be submitted forty-five (45) days prior to expiration of the existing plan. (7-1-25)T

06. Addendums. A service plan may be adjusted with an addendum when based on changes in participant needs, requested and signed by a decision-making authority, and PA by the Department. The Department distributes the addendum to providers involved in implementation. Providers must review an addendum upon receipt, and sign and return it to the Department, maintaining a copy in the participant's record. (7-1-25)T

07. Annual Reauthorization for State Plan and Family-Directed Community Supports (FDCS). (7-1-25)T

584. CHILDREN'S DD HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. Supervision. All providers must be supervised by an intervention specialist or professional. Observation and review of direct services must be performed monthly, or more often as needed, ensuring staff demonstrate the necessary skills to correctly provide services. (7-1-25)T

02. Quality Assurance. Providers must demonstrate high quality of services through internal quality assurance reviews. (7-1-25)T

03. Documentation. Providers must maintain records for each participant served. Failure to maintain documentation results in recoupment of payments for undocumented services. Documentation must include: (7-1-25)T

a. Visit date and time in and out; (7-1-25)T

b. Services provided; (7-1-25)T

c. Session summary; (7-1-25)T

d. Service location; and (7-1-25)T

e. Signature of the provider and date signed. (7-1-25)T

585. CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.

01. Respite. Provided by a DDA or an independent provider meeting these minimum qualifications: (7-1-25)T

a. Be at least sixteen (16) years old when employed by a DDA or eighteen (18) years old when an

independent provider; (7-1-25)T

b. Receive instructions in the participant's needs; (7-1-25)T

c. Demonstrate ability to provide services according to a service plan; and (7-1-25)T

d. Obtain and maintain CPR and first aid certification prior to delivering services. (7-1-25)T

02. Community-Based Support. Provided by a DDA or an independent provider meeting these minimum qualifications: (7-1-25)T

a. Be at least eighteen (18) years old; (7-1-25)T

b. Receive instructions in the participant's needs; (7-1-25)T

c. Demonstrate ability to provide services according to a service plan; (7-1-25)T

d. Be supervised or have six (6) months supervised experience working with children with DD. (7-1-25)T

e. Complete coursework approved by the Department demonstrating competencies related to providing community-based supports; and (7-1-25)T

f. Obtain and maintain CPR and first aid certification prior to delivering services alone. (7-1-25)T

03. Family Education. Provided by a DDA or an independent intervention specialist or professional. (7-1-25)T

586. CHILDREN'S DD HCBS STATE PLAN OPTION: REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis for services identified on a participant's service plan. (7-1-25)T

587. – 589. (RESERVED)

ADULT DD HCBS STATE PLAN OPTION
(Sections 590-609)

590. ADULT DD HCBS STATE PLAN OPTION.
DD state plan services are provided through an HCBS State Plan option for adults with DD, and who do not meet ICF/IID level of care. (7-1-25)T

591. ADULT DD HCBS STATE PLAN OPTION: ELIGIBILITY.
Individuals must be eighteen (18) years or older, live in the community, and meet DD determination standards. (7-1-25)T

592. COMMUNITY CRISIS SUPPORTS.
Interventions for participants determined eligible for Adult DD HCBS State Plan services who risk losing housing, employment, income, or at risk of incarceration, physical harm, or family altercations. (7-1-25)T

593. COMMUNITY CRISIS SUPPORTS: COVERAGE AND LIMITATIONS.
Services are authorized after an intervention when a documented need for immediate intervention exists, no other supports were available, and services were appropriate to rectify the crisis. Services are limited to a maximum of twenty (20) hours during any consecutive 5-day period. (7-1-25)T

01. Emergency Room (ER). Services may be provided in an ER during the evaluation process if the goal is to prevent hospitalization and return to the community. (7-1-25)T

02. Before Plan Development. Services may be provided before completion of the service plan when

the service plan includes identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (7-1-25)T

03. Crisis Resolution Plan. After services are provided, the provider must complete and submit a crisis resolution plan to the Department for approval within five (5) business days. (7-1-25)T

594. – 599. (RESERVED)

600. DEVELOPMENTAL THERAPY.
The Department pays for services to eligible participants with recommendations from a medical provider and provided by licensed DDAs. (7-1-25)T

601. (RESERVED)

602. DEVELOPMENTAL THERAPY: COVERAGE AND LIMITATIONS.

01. Coverage. Developmental therapy is delivered in a DDA center-based program, the community, or the participant's home, and includes individual developmental therapy and group developmental therapy. Services must: (7-1-25)T

a. Be directed toward rehabilitation or habilitation of physical or DDs in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-25)T

b. Include age-appropriate instruction in ADLs not gained by a participant during normal developmental stages or not likely to develop without training or therapy. (7-1-25)T

c. Not include tutorial activities or assistance with educational tasks associated with educational needs resulting from a disability. (7-1-25)T

d. Both individual and group therapy must be available based on participant needs, interests, or choices. (7-1-25)T

e. Include a minimum of one (1) qualified staff member providing direct services for every twelve (12) participants when center based. (7-1-25)T

f. Occur in integrated, inclusive settings with no more than three (3) participants per qualified staff at each community-based session. Additional staff must be added when necessary to meet the needs of each individual served. (7-1-25)T

02. Limitations. Developmental therapy may not exceed these limitations: (7-1-25)T

a. No more than twenty-two (22) hours per week. (7-1-25)T

b. No more than forty (40) hours per week in combination with ADH and supported employment. (7-1-25)T

c. Only one (1) type of Medicaid-reimbursable therapy during a single period. (7-1-25)T

d. Cannot be reimbursed when providing transportation to and from the agency. (7-1-25)T

603. DEVELOPMENTAL THERAPY: INDIVIDUAL SERVICE PLAN (ISP) REQUIREMENTS.

01. Intake. Prior to service delivery, DDAs must obtain a participant's current MSDA and authorized ISP. (7-1-25)T

02. Plan Changes. Changes to the ISP or PIP must be documented in the participant's record, and

include the reason for the change, the date of change, and the name and title of the professional making the change. (7-1-25)T

604. DEVELOPMENTAL THERAPY: INDIVIDUAL PROGRAM PLAN (IPP) PROCEDURAL REQUIREMENTS.

01. Intake. Participants receiving HCBS A&D waiver services or PCS only requesting Developmental Therapy, may access services using an IPP, which does not require a DD plan developer. Services delivered through an IPP must be authorized by the Department and be based on the A&D waiver Service Plan. Prior to service delivery, a DDA must complete an IPP that meets the standards below. (7-1-25)T

02. IPP Development. IPPs must: (7-1-25)T

a. Be developed after completion of all required assessments; (7-1-25)T

b. Be signed prior to delivery of services by a medical provider, the participant, and their legal guardian if applicable; (7-1-25)T

c. Be developed at least annually, or more often, when necessary, to review or update the IPP to reflect any changes in the participant's needs or status; and (7-1-25)T

d. Promote self-sufficiency, participant choice in program objectives and activities, encourage participant's participation and inclusion in the community, and contain age-appropriate objectives. (7-1-25)T

03. IPP Changes. Changes to an IPP require notification and written authorization by the participant and their legal guardian if one (1) exists. Changes in type, amount, or duration of services must be recommended by a medical provider in writing. If the signatures of the participant or their legal guardian cannot be obtained, the DDA must document in the participant's record why signatures were not obtained. PIP changes must include the following documentation in the participant's record: (7-1-25)T

a. Reason for a change; (7-1-25)T

b. Coordination with other service providers, when applicable; (7-1-25)T

c. Date of change; and (7-1-25)T

d. Signature, date, credentials, and title of the professional making the change. (7-1-25)T

605. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.
DDAs must obtain all assessments required for DD services eligibility, billing no more than four (4) hours for the combination of all assessment, evaluation, or diagnostic services provided in a calendar year. The following assessment and diagnostic services are reimbursable: (7-1-25)T

01. Comprehensive Developmental Assessment. Assessments must: (7-1-25)T

a. Be conducted by a Developmental Specialist and determine necessity of a service, guide treatment, and identify the participant's current strengths, needs, and interests. (7-1-25)T

b. Be signed and dated by the professional completing the assessment, including their appropriate professional credentials or qualifications. (7-1-25)T

c. Reflect the current status of the participant with assessments completed or updated at least every two (2) years. (7-1-25)T

d. Reflect a person's developmental status in the following areas: (7-1-25)T

i. Self-care; (7-1-25)T

ii. Receptive and expressive language; (7-1-25)T

iii. Learning; (7-1-25)T

iv. Gross and fine motor development; (7-1-25)T

v. Self-direction; (7-1-25)T

vi. Capacity for independent living; and (7-1-25)T

vii Economic self-sufficiency. (7-1-25)T

02. Specific Skill Assessments. These assessments must: (7-1-25)T

a. Further assess an area of limitation or deficit identified on a comprehensive developmental assessment. (7-1-25)T

b. Relate to a goal on an IPP or ISP. (7-1-25)T

c. Be conducted by qualified professionals to determine a participant's skill level within an area. (7-1-25)T

d. Be used to determine baselines and develop a PIP. (7-1-25)T

03. Documentation Requirements. DDAs must maintain records for each participant served. Each record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following documentation is required: (7-1-25)T

a. Daily entry of all activities conducted toward meeting their objectives. (7-1-25)T

b. Sufficient progress data accurately assessing a participant's progress toward each objective; (7-1-25)T

c. Review of data, and, when applicable, changes in the daily activities or implementation procedures by the qualified professional, including their dated initials. (7-1-25)T

d. Documentation for six (6) month and annual reviews by the Developmental Specialist including a written description of the participant's progress toward their achievement of therapeutic goals, and reasons they continue to need services. (7-1-25)T

e. Authorized service plan. (7-1-25)T

04. PIP Requirements. The DDA must develop a PIP for each DDA objective included on the participant's IPP or ISP. All PIPs must relate to a goal or objective on the participant's IPP or ISP. PIPs must be developed within fourteen (14) days of service start date or receipt of an authorized IPP or ISP and be revised whenever participant needs change. If the PIP is not completed within fourteen (14) days, the participant's records must contain participant-based documentation justifying the delay. The provider addresses goals and objectives as agreed to by the participant until the annual PIP is completed and documents service delivery related to their interim goals and objectives. The PIP must include: (7-1-25)T

a. Participant's name. (7-1-25)T

b. A baseline statement addressing the participant's skill level and abilities related to specific skills to be learned. (7-1-25)T

c. Measurable, behaviorally stated objectives corresponding to the goals or objectives authorized in

the service plan. (7-1-25)T

d. Written instructions for staff that include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward stated objectives. (7-1-25)T

e. Identification of the environments where services are provided. (7-1-25)T

f. Target date for completion. (7-1-25)T

05. Informed Objectives. Results from a psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided by the DDA accommodate the participant's mental health needs and none of the therapeutic methods are contra-indicated or delivered in a manner that presents risks to the participant's mental health status. (7-1-25)T

606. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialists. Developmental Specialists for adults must have two hundred forty (240) hours of professionally supervised experience with individuals with DD and either: (7-1-25)T

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-25)T

b. Possess a bachelor's or master's degree in any area and have: (7-1-25)T

i. Completed a competency course approved by the Department relating to Developmental Specialist job requirements; and (7-1-25)T

ii. Passed a Department-approved competency examination. (7-1-25)T

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, may continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-25)T

02. Developmental Therapy Paraprofessionals. Paraprofessionals who are at least seventeen (17) years old may be used by a DDA to provide developmental therapy when under the supervision of a Developmental Specialist. (7-1-25)T

03. Collaboration with Other Providers. When participants receive rehabilitative or habilitative services from other providers, the DDA must coordinate each participant's program with their providers to maximize skill acquisition and generalization of skills across environments and avoid duplication of services. DDAs must maintain documentation of any collaboration that includes other service plans. Participant's files must also reflect how all services are integrated into a DDA's plan for each participant. (7-1-25)T

607. STAFFING REQUIREMENTS.

01. Paraprofessional Standards. When a paraprofessional provides developmental therapy, the DDA must ensure adequate supervision by a Developmental Specialist during service hours. The following standards apply: (7-1-25)T

a. DDAs must ensure paraprofessionals do not conduct assessments, establish service plan, or develop a PIP. These activities are conducted by a Developmental Specialist. (7-1-25)T

b. On a weekly basis or more often, if necessary, DDAs must ensure a Developmental Specialist is available for all paraprofessionals under their supervision to give instructions, review progress, and provide training

on the programs and procedures. (7-1-25)T

c. DDAs must ensure that a Developmental Specialist, on a monthly basis or more often, if necessary, observes and reviews the work performed by paraprofessionals under their supervision, to ensure they are trained on the programs and demonstrate necessary skills to correctly implement them. (7-1-25)T

02. Agency Staffing Requirements. Each DDA must employ an administrator accountable for all service elements and who is employed on a continuous, regularly scheduled basis. The administrator is accountable for the overall operations of the DDA including ensuring compliance with rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (7-1-25)T

a. When the administrator is not a Developmental Specialist, the DDA must employ a Developmental Specialist on a continuous, regularly scheduled basis who is responsible for the service elements of the agency; and (7-1-25)T

b. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing DD services to individuals with DD. (7-1-25)T

608. – 609. (RESERVED)

ADULT DD HCBS WAIVER SERVICES
(Sections 610-629)

610. ADULT DD WAIVER SERVICES.
The Department provides waiver services to eligible participants, preventing unnecessary institutionalization, allowing the greatest degree of independence possible, enhancing the quality of life, encouraging individual choice, and achieving and maintaining community integration. (7-1-25)T

611. ADULT DD WAIVER SERVICES: PARTICIPANT ELIGIBILITY.
The Department determines waiver eligibility. The participant must meet the following: (7-1-25)T

01. Age. Be eighteen (18) years or older. (7-1-25)T

02. Eligibility. The Department must determine whether: (7-1-25)T

a. The participant would qualify for ICF/IID level of care if the DD waiver services were not available; (7-1-25)T

b. The participant can reside safely and effectively in a non-institutional setting; and (7-1-25)T

c. The average annual cost of a participant’s waiver and other medical services do not exceed the average annual cost to Medicaid for ICF/IID care and other medical costs. (7-1-25)T

03. DD Waiver Eligibility. Participants eligible for DD waiver services may instead choose admission to an ICF/IID. (7-1-25)T

04. Redetermination. (7-1-25)T

a. Financial and medical redetermination are conducted annually or sooner at the request of the participant, self-reliance, a provider agency, or medical provider. (7-1-25)T

b. The redetermination process will assess the participant's continued need and eligibility for waiver services and discharge from the waiver services program. (7-1-25)T

05. Notifications. The Department notifies participants of the eligibility decision after an assessment. Notification includes an individualized explanation of the decision and how they may appeal. (7-1-25)T

06. Adult DD Waiver Limits. The number of Medicaid participants to receive waiver services under the Adult DD waiver is limited to the projected number of users in a CMS-approved waiver. Individuals applying for this waiver after the maximum is reached are placed on a waiting list to have their applications processed after September 30th for the new DD waiver year. (7-1-25)T

612. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. An integrated array of individually tailored services and supports designed to assist participants reside successfully in their own homes, with their families, or in CFHs. The number of residents in a setting will be limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. Residential Habilitation consists of the following: (7-1-25)T

a. Habilitation services to help an individual acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity, and include training in at least one (1) of the following areas: (7-1-25)T

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (7-1-25)T

ii. Money management; (7-1-25)T

iii. Daily living skills; (7-1-25)T

iv. Socialization not including participation in non-therapeutic activities that are diversional or recreational in nature; (7-1-25)T

v. Mobility; and (7-1-25)T

vi. Behavior shaping and management. (7-1-25)T

b. Personal Assistance Services that assist an individual in ADL, household tasks, and other routine activities as the participant or their primary caregivers are unable to accomplish on their own. (7-1-25)T

c. Skills training to teach participants and supports to perform activities with greater independence and to reinforce habilitation training. (7-1-25)T

02. Chore Services. Intermittent assistance or chore activities when necessary to maintain functional use of the participant's home or to provide a clean, sanitary, and safe environment. Services are only available when neither the participant, nor anyone else in the home, is capable of performing or financially providing for them, and when no other non-paid support, landlord, agency, or third-party payer is willing or able to provide. Services are limited to those provided in a home rented or owned by the participant. For rental property, the Department examines the lease agreement for landlord responsibilities prior to any authorization of service. (7-1-25)T

03. Respite Care. Short-term breaks from caregiving responsibilities to non-paid caregivers. The caregiver or participant selects, trains, and directs the provider. While receiving respite care, participants cannot receive other duplicative services. Respite care does not include room and board payments. Services may be provided in the participant's residence, the respite provider's home, the community, a CFH, a DDA, or an ADH facility. (7-1-25)T

04. Supported Employment. Competitive work in integrated work settings for individuals for whom competitive employment has not traditionally occurred; or when competitive employment is interrupted or intermittent due to severe disability. The nature and severity of an individual's disability requires intensive supported employment services or extended services to work. This service is not available when funded under another program. (7-1-25)T

05. Non-Medical Transportation (NMT). Transportation enabling a participant to access waiver and other community services and resources. Whenever possible, non-paid supports or public transit providers are used. (7-1-25)T

06. Environmental Accessibility Adaptations. Minor housing adaptations necessary for a participant to function with greater independence in their home, or without which, would require institutionalization or pose a risk to health or safety, including: (7-1-25)T

a. Installations or modifications necessary to accommodate medical equipment and supplies necessary for the health and safety of the participant but excludes those that are not of direct medical or remedial benefit to the participant. (7-1-25)T

b. Unless otherwise authorized, permanent modifications are limited to the participant's principal residence that is owned by the participant or their non-paid family. (7-1-25)T

c. Portable or non-stationary modifications may be made when the participant or their non-paid family rents a home, and modifications follow a participant to their next residence. (7-1-25)T

07. Specialized Medical Equipment and Supplies. (7-1-25)T

a. Devices, controls, or appliances enabling a participant to increase their abilities to perform ADL, or to perceive, control, or communicate with the environment in which they live. (7-1-25)T

b. Items necessary for life support, ancillary supplies, and equipment necessary for the proper functioning of such items, and DME and non-DME not available under State Plan or EPSDT. (7-1-25)T

c. Items reimbursed under this waiver exclude items that are not of direct medical or remedial benefit to the participant. (7-1-25)T

08. Personal Emergency Response System (PERS). Electronic devices enabling participants to secure help in an emergency which connects to a participant’s phone and is programmed to signal a response center when activated. The response center is staffed by trained professionals. PERS is limited to participants who rent or own a home, or live with unpaid caregivers, are alone for extended periods with no caregiver, and require extensive, routine supervision. (7-1-25)T

09. Home Delivered Meals. Meals delivered to a participant’s home that promote adequate nutrition. Participants can receive one (1) to two (2) meals per day when they rent or own a home, are alone for extended periods with no caregiver, and are unable to prepare a meal without assistance. (7-1-25)T

10. Skilled Nursing. Intermittent or continuous oversight, training, or skilled care within the scope of the Nurse Practice Act provided by an RN or LPN under the supervision of an RN. Services cannot cost more than a Home Health visit. (7-1-25)T

11. Behavior Consultation/Crisis Management. Direct consultation and clinical evaluation of participants currently experiencing, or expected to experience, a psychological, behavioral, or emotional crisis. Services may provide training and staff development related to the participant’s needs and provide emergency back-up involving the direct support for a participant in crisis. (7-1-25)T

12. Adult Day Health. Supervised, structured services provided outside the participant’s home in a non-institutional, community-based setting, and encompassing health and social services, recreation, supervision for safety, and assistance with ADL needed to ensure optimal function of the participant. Services do not include room and board payments. (7-1-25)T

13. Self-Directed Community Supports. DD waiver participants may choose to self-direct an individualized budget rather than receive traditional waiver services. (7-1-25)T

14. Transition Services. Goods and services enabling a participant residing in a NF, hospital, IMD, or

ICF/IID to transition to a community-based setting immediately following discharge from a facility after a minimum of forty-five (45) days. (7-1-25)T

a. Services may include: (7-1-25)T

i. Security deposits required to obtain a lease on an apartment or home; (7-1-25)T

ii. Cost of essential household furnishings; (7-1-25)T

iii. Set-up fees or deposits for utility or service access; (7-1-25)T

iv. Services necessary for health and safety prior to occupancy; (7-1-25)T

v. Moving expenses; and (7-1-25)T

vi. Activities to assess need, arrange for, and procure transition services. (7-1-25)T

b. Exclusions. Ongoing expenses (including utilities), real property, décor, or entertainment and recreational items. (7-1-25)T

c. Limitations: A total cost of two thousand dollars ($2,000) per participant and only accessed every two (2) years, following a qualifying transition. Services are furnished when a participant is unable to meet an expense or when a support cannot be obtained from other sources. (7-1-25)T

15. Limitations. Participants cannot receive DD waiver services in non-HCBS settings or RALFs. (7-1-25)T

613. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Authorization. All waiver services must be identified on a service plan and authorized by the Department. The service plan must be reviewed by a plan monitor or service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. (7-1-25)T

02. Documentation Required. (7-1-25)T

a. Written documentation of each visit made or service provided to a participant including: (7-1-25)T

i. Service date; (7-1-25)T

ii. Service(s) provided; (7-1-25)T

iii. Statement of the participant's response to services, including any changes in the participant's condition; (7-1-25)T

iv. Length of visit, including time in and out. Unless a participant is determined by a Service Coordinator to be unable to do so, the delivery is verified by the participant by signing the service record; and (7-1-25)T

v. A copy of the above information is maintained in the participant's home unless the Department authorizes elsewhere. Failure to maintain documentation results in recoupment for undocumented services. (7-1-25)T

b. Service plans must specify the services required by a participant. A copy maintained in the participant's home must be available to all service providers and the Department. (7-1-25)T

c. PIP and provider status reviews, if required. (7-1-25)T

03. Provider Notification. Providers must notify the plan monitor and document on the service record

when any significant changes in participant's condition are noted during service delivery. (7-1-25)T

614. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Residential Habilitation – Supported Living. Employment by a licensed residential habilitation agency. Direct care staff must: (7-1-25)T

a. Be at least eighteen (18) years old; (7-1-25)T

b. Be free from communicable disease; (7-1-25)T

c. Demonstrate the ability to administer the plan of service; (7-1-25)T

d. Have a valid driver's license and vehicle insurance, if transporting participants; (7-1-25)T

e. Receive training by a QIDP who has demonstrated experience in writing skill training programs. Training programs must include an orientation program completed before providing services, and additional ongoing training during employment. (7-1-25)T

02. Residential Habilitation – CFH. Individuals providing direct services in their own home must be a CFH, receive program coordination provided through the Department, and: (7-1-25)T

a. Be free from communicable disease; (7-1-25)T

b. Have a valid driver's license and vehicle insurance, if transporting participants; and (7-1-25)T

c. Have certification or licensure to perform tasks requiring certification or licensure. (7-1-25)T

d. Prior to delivering services to a participant, complete an orientation training provided by the Department and additional training requirements for CFH providers within six (6) months of certification date. (7-1-25)T

03. Chore Services. Be skilled in the service to be provided and demonstrate the ability to follow a service plan. (7-1-25)T

04. Respite Care. Receive instructions in the participant's needs, demonstrate the ability to follow a service plan, and be free of communicable disease. (7-1-25)T

05. Supported Employment. Provided by an agency accredited by CARF or meet State requirements to be an agency. (7-1-25)T

06. Non-Medical Transportation. Possess a valid driver's license and vehicle insurance. (7-1-25)T

07. Specialized Medical Equipment. Enrollment as a supplier and ensure all items meet applicable standards of manufacture, design, and installation. Preference is given to the most cost-effective option to meet the participant's needs. (7-1-25)T

08. PERS. Demonstration that the devices installed in a participant's home meet FCC standards. (7-1-25)T

09. Home-Delivered Meals. Provided by a public agency or business ensuring: (7-1-25)T

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the USDA; (7-1-25)T

b. Meals are delivered in a sanitary manner, and at the correct temperature for the specific type of food; and (7-1-25)T

c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. (7-1-25)T

10. Behavior Consultation or Crisis Management. (7-1-25)T

a. Work under the direct supervision of a psychologist or PhD in Special Education with training and experience treating severe behavior problems and applied behavior analysis; and (7-1-25)T

i. Have a Master's degree in a behavioral science or a closely related field; (7-1-25)T

ii. Be a licensed pharmacist; or (7-1-25)T

iii. Be a QIDP. (7-1-25)T

b. Emergency back-up providers must meet the qualifications of a residential habilitation agency. (7-1-25)T

11. Adult Day Health. (7-1-25)T

a. Services provided in a facility must meet the building and health standards under IDAPA 16.03.21; (7-1-25)T

b. Provide care and supervision appropriate to the participant's needs as identified on the plan. (7-1-25)T

c. Free from communicable disease. (7-1-25)T

12. Transition Services. Transition managers. (7-1-25)T

615. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.
Reimbursement rates for services include both services and mileage. Mileage for provider transportation to and from the service delivery location is not reimbursable. (7-1-25)T

616. – 619. (RESERVED)

620. HEALTH HOME.
The Intellectual Disability/Mental Illness (ID/MI) Health Home is a multi-disciplinary team providing an array of person-centered healthcare services to eligible participants transitioning across systems of care and living in the least restrictive environment possible. (7-1-25)T

621. HEALTH HOME: ELIGIBILITY REQUIREMENTS.
Participants diagnosed with an intellectual disability and a Serious Mental Illness, or Autism, and their acuity exceeds the existing level of traditional community services. Eligibility will be determined by the Department. Participants must receive one (1) Health Home service per month to maintain eligibility. (7-1-25)T

622. HEALTH HOME: COVERAGE AND LIMITATIONS.
Health home services include comprehensive case management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. (7-1-25)T

623. HEALTH HOME: PROCEDURAL REQUIREMENTS.
Idaho Medicaid and ID/MI Health Home will coordinate Health Home services through an intra-agency agreement published on the Department's website. (7-1-25)T

624. HEALTH HOME: PROVIDER QUALIFICATIONS AND DUTIES.
The ID/MI Health Home will be administered by the Department. Providers of Health Home services must be

employed by, or contracted with, the ID/MI Health Home and meet all staff qualifications as specified in the intra-agency agreement. (7-1-25)T

625. HEALTH HOME: PROVIDER REIMBURSEMENT.
Reimbursement for Health Home services will be paid per the fee schedule. (7-1-25)T

626. – 629. (RESERVED)

**SUB AREA: SERVICE COORDINATION
(Sections 630-639)**

630. SERVICE COORDINATION: DEFINITIONS.

01. Conflict of Interest. A situation in which an agency or person directly or indirectly influences, or appears to influence, the direction of a participant to other services for financial gain. (7-1-25)T

02. Crisis. An unanticipated event, circumstance, or life situation placing a participant at risk of hospitalization, loss of housing, loss of employment or major source of income, incarceration, or physical harm to self or others, including family altercation or psychiatric relapse. (7-1-25)T

631. SERVICE COORDINATION: PARTICIPANT ELIGIBILITY.

01. Adults. A DD diagnosis and a need for assistance to access service and supports necessary to maintain their independence. (7-1-25)T

02. Children. All information necessary to make an eligibility determination must be received by the Department twenty (20) business days prior to the anticipated service coordination start date. The Department determines eligibility based on information provided by the service coordination agency or the family prior to the initiation of initial and ongoing plan development and services. Participants must meet the following requirements: (7-1-25)T

a. Age of thirty-seven (37) months through the month of their 21st birthday. (7-1-25)T

b. A diagnosis with special health care needs requiring medical and multidisciplinary rehabilitation services identified by a medical provider to prevent or minimize disability. (7-1-25)T

c. Reimbursement for services is not available for participants whose needs can be met by other paid or unpaid sources. The child must require service coordination for one (1) or more of the following: (7-1-25)T

i. A condition resulting in functioning below normal age level in one (1) or more life areas; (7-1-25)T

ii. At risk of placement in a more restrictive environment or returning a child from an out of home placement due to their condition; (7-1-25)T

iii. Danger to the health or safety of the child exists or a parent is unable to meet the child's needs; (7-1-25)T

iv. Further complications may occur due to the condition without service coordination; or (7-1-25)T

v. Requires multiple service providers and treatments. (7-1-25)T

632. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
The Department covers service coordination for individuals who are unable, or have limited ability to gain access, coordinate, or maintain services on their own or through other means. These rules are not applicable to case management services provided under the managed care contracts. (7-1-25)T

01. Plan Assessment and Reassessment. Activities required when determining participant needs during plan development and reassessment that include completing documentation related to a participant's history, identifying a participant's needs, and gathering information to form a complete assessment of the participant. (7-1-25)T

02. Plan Development. Development and revision of a service coordination plan including information collected through the assessment and specifying goals and actions needed by the participant. Plans must be updated annually or as needed to meet participant needs. (7-1-25)T

03. Monitoring and Follow-Up. Contacts necessary to ensure a plan is implemented and adequately addresses a participant's needs and conducted as frequently as necessary. Activities must include one (1) or more face-to-face contacts with a participant at least every ninety (90) days and may occur via synchronous virtual care to determine: (7-1-25)T

a. Services are provided according to the plan; (7-1-25)T

b. Services in the plan are adequate; and (7-1-25)T

c. Whether there are changes in the needs or status of a participant, requiring adjustments to the plan or service arrangements with providers. (7-1-25)T

04. Crisis Assistance. Coordination used to help a participant access community resources to resolve a crisis that does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. (7-1-25)T

a. Crisis Assistance hours are unavailable until all available hours of service coordination have already been provided in the month. (7-1-25)T

b. Authorization for crisis assistance is requested retroactively due to a crisis when a participant's service coordination benefits are exhausted, and no other support is available. A service coordinator must complete a crisis resolution plan and submit a request for crisis services to the Department within five (5) business days of the last day of providing the service. (7-1-25)T

05. Contacts. Service coordination may include contacts with non-eligible individuals only when a contact directly relates to identifying the needs and supports to help a participant access services. (7-1-25)T

06. Exclusions. Service coordination does not include activities that are integral components of another covered service, integral to administration of foster care programs, or integral to administration of another program a participant is eligible for, except case management required by IDEA. (7-1-25)T

07. Limitations. (7-1-25)T

a. Providers may only deliver service coordination and direct services to the same Medicaid participant when they receive children's services coordination. (7-1-25)T

b. Service coordination cannot exceed four point five (4.5) hours per month, unless accessing unused hours in an individual's current plan from previous months. (7-1-25)T

c. Reimbursement for annual assessment and plan development cannot exceed twelve (12) hours per year. (7-1-25)T

d. Participants receiving hospice services or who live in hospitals, NFs, or ICF/IIDs are not eligible for service coordination. (7-1-25)T

e. Participants are only eligible for one (1) type of service coordination. Participants who qualify for more than one (1) type, must choose one (1) that best meets their needs. (7-1-25)T

f. Group services are not reimbursable. (7-1-25)T

g. Missed appointments, attempted contacts, travel to provide services, leaving messages, scheduling appointments with a Medicaid-enrolled service coordinator, transporting participants, or documenting services are not reimbursable. (7-1-25)T

633. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. (7-1-25)T

02. Plan Development. A plan must be developed and implemented within sixty (60) days after a participant chooses a service coordinator. (7-1-25)T

03. Documentation. Agencies must maintain documentation describing services provided, reviewing the continued need for service coordination, and progression towards each service coordination goal. (7-1-25)T

04. Freedom of Choice. A participant must have freedom of choice when selecting providers. (7-1-25)T

05. Contact and Availability. The plan must identify the frequency, mode of contact, and provider to be contacted, which must meet the participant's needs. The plan must also identify the frequency of face-to-face contact with each participant. (7-1-25)T

a. When a provider must conduct a face-to-face contact with a child without a parent or legal guardian present, the provider must notify them prior to the contact and document the notification in the participant's file. (7-1-25)T

b. Providers do not have to be available twenty-four (24) hours a day but must include an individualized objective on the plan describing who to contact in an emergency and how the provider will obtain needed services during an emergency. (7-1-25)T

06. Conflict of Interest. Providers must be alert to, and avoid, conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. They must inform the participant, parent, or legal guardian when a real or potential conflict of interest arises, take reasonable steps to resolve the issue with the participant's interests first, and protect their interests to the greatest extent possible. (7-1-25)T

a. Providers developing a participant's plan cannot: (7-1-25)T

i. Be related by blood or marriage to the participant or to any paid caregiver of the participant; (7-1-25)T

ii. Be financially responsible for the participant; (7-1-25)T

iii. Make financial or health-related decisions on behalf of the participant; (7-1-25)T

iv. Hold financial interests in any entity paid to provide care for the participant; or (7-1-25)T

v. Provide any State Plan HCBS or waiver services to the participant or have an interest in or be employed by providers for the participant. (7-1-25)T

b. Agencies must guard against conflicts of interest and ensure its employees and contractors meet the conflict-of-interest standards. They must include documentation in each participant's file, signed by the participant, parent and or legal guardian, that defines "conflict of interest," and includes a provider-signed statement verifying that conflict of interest was reviewed and explained. (7-1-25)T

634. SERVICE COORDINATION: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Agreement. Providers must be employees or contractors of an agency. (7-1-25)T

02. Supervision. Agencies must provide supervision to all providers by clearly documenting each supervisor's ability to address concerns about the services provided under their supervision. (7-1-25)T

03. Supervisor Requirements. (7-1-25)T

a. Master's Degree in a human services field, and twelve (12) months supervised work experience with the population served; or (7-1-25)T

b. Bachelor's degree in a human services field or RN, and twenty-four (24) months supervised work experience with the population served. (7-1-25)T

04. Service Coordinator Requirements. (7-1-25)T

a. Bachelor's degree in a human services field or RN and twelve (12) months supervised work experience with the population served. (7-1-25)T

b. Individuals meeting education or licensing requirements but without the required supervised work experience must be supervised by a qualified service coordinator while gaining the required work experience. (7-1-25)T

05. Paraprofessional Requirements. Under the supervision of a qualified service coordinator, a paraprofessional can assist in the implementation of the plan. Paraprofessionals cannot conduct assessments, evaluations, person-centered planning meetings, 90-day face-to-face contacts, 180-day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as a service coordinator on the plan and cannot supervise service coordinators or other paraprofessionals. They must: (7-1-25)T

a. Be eighteen (18) years or older with a high school diploma or equivalency and twelve (12) months supervised work experience with the population served; and (7-1-25)T

b. Be able to read and write at a level necessary to process all paperwork and forms required for service delivery. (7-1-25)T

06. Health, Safety, and Fraud Reporting. Providers must report any concerns about fraud, health, and safety to the appropriate governing agency and the Department. (7-1-25)T

07. Case Loads. The total caseload of a provider must assure quality service delivery and participant satisfaction. (7-1-25)T

635. SERVICE COORDINATION: PLAN DEVELOPMENT – ASSESSMENT.

Service coordinators must complete the service coordination assessment as part of person-centered planning to identify a participant's need for assistance accessing and coordinating care and services. The participant's needs and supports must be documented in the assessment. The participant, parent, legal guardian, and other providers identified by the participant must be included in the process. The assessment is used to determine a participant's prioritized needs and services which must be documented in the plan. For children, assessments must identify the family's needs to ensure their child's needs are met. (7-1-25)T

636. SERVICE COORDINATION PLAN.

The plan must specify goals and actions addressing the service coordination needs of a participant identified in the assessment. The service coordination plan for adults with DD must comply with and be incorporated into their DD service plan. (7-1-25)T

637. SERVICE COORDINATION: REIMBURSEMENT.

01. Duplication. Payments must not duplicate payment made under similar programs. (7-1-25)T

02. Payment. Reimbursable services include plan development, face-to-face contact, two-way communication between a service coordinator and a participant, their other providers, family members, primary caregivers, legal guardian or other interested persons, and referrals or related activities to obtain needed services identified in the plan. (7-1-25)T

03. Medical Institutionalization. Service coordination reimbursement for the day a participant is admitted to or discharged from a medical facility is allowed when the service occurs prior to admission or after discharge. (7-1-25)T

a. Services that help a participant reintegrate into the community are only reimbursable when provided during the last fourteen (14) days for inpatient stays under one hundred eighty (180) days or the last sixty (60) days for inpatient stays one hundred eighty (180) days or more. Claims cannot be filed for services provided until after participant discharge. (7-1-25)T

b. Services must not duplicate activities provided during a facility's admission or discharge process. (7-1-25)T

04. Delivered Prior to Assessment. On-going service coordination is not allowable prior to completion of a plan. (7-1-25)T

638. – 639. (RESERVED)

YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION (Sections 640-649)

640. YES HCBS STATE PLAN OPTION: INDEPENDENT ASSESSMENT.
Comprehensive clinical diagnostic assessment using a Department-approved tool identifying a child's needs, strengths, and degree of functional impairment, administered by a Department-designated independent assessor. The assessment process includes: (7-1-25)T

01. Evaluation. The child's current behavioral health, living situation, relationships, and family functioning; (7-1-25)T

02. Contact. Necessary contacts with significant individuals; and (7-1-25)T

03. History. Review of a child's clinical, educational, social, and behavioral health, and juvenile justice history. (7-1-25)T

641. YES HCBS STATE PLAN OPTION: REDETERMINATION.
Eligibility is redetermined by an independent assessment every twelve (12) months. The Department may extend eligibility to allow for unavoidable delays. (7-1-25)T

642. YES HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.

01. Respite Care. Supervision of a participant on an intermittent or short-term basis allowing relief to a primary unpaid caregiver of a YES participant in response to a family emergency or crisis, or on a regular basis to provide caregiver relief. Payment and administration of respite care is done through managed care contracts. (7-1-25)T

02. Person-Centered Planning. A person-centered planning team directs the development of the service plan. (7-1-25)T

643. – 649. (RESERVED)

SUB AREA: HOSPICE (Sections 650-659)

650. HOSPICE.
Medicaid pays for hospice services based on Medicare program coverage. (7-1-25)T

651. HOSPICE: DEFINITIONS.

01. Benefit Period. Period beginning the first day of the month a participant elects hospice and ending the last day of the 11th successive calendar month. (7-1-25)T

02. Election Period. One (1) of eight (8) periods within a benefit period that a participant may elect to receive hospice care. Each period consists of any calendar month, or portion thereof, chosen within a benefit period. (7-1-25)T

03. Hospice Agency. Public agency or private organization that primarily provides care to terminally ill participants and meets the Medicare conditions for certification. (7-1-25)T

652. HOSPICE: ELIGIBILITY.
Hospice eligibility requires: (7-1-25)T

01. Certification of Participant Terminal Illness. (7-1-25)T

02. Medically Necessary. For the palliation and management of a terminal illness and related conditions. (7-1-25)T

03. Participant Election of Services. (7-1-25)T

04. Informed Consent. Participants must receive education on the reason for and nature of hospice care prior to service delivery. (7-1-25)T

653. HOSPICE: COVERAGE AND LIMITATIONS.
Core services and requirements include those in 42 CFR 418.64, 42 CFR 418.76, 42 CFR 418.106, 42 CFR 418.108, 42 CFR 418.110, 42 CFR 418.112, and physical, occupational, and speech-language therapy services provided for symptom control or enabling a participant to maintain ADLs and basic functional skills. (7-1-25)T

654. HOSPICE: PROCEDURAL REQUIREMENTS.

01. Physician Certification. The hospice must obtain certification of a participant's terminal illness as follows: (7-1-25)T

a. For any period of coverage, the provider must obtain, no later than two (2) calendar days after initiating care, written certification statements signed by the hospice medical director or a physician member of a hospice interdisciplinary group and the participant's attending physician, when applicable. Certification must verify a participant's life expectancy is six (6) months or less. If a participant's medical prognosis or the appropriateness of hospice care is questionable, the Department can obtain another physician's opinion to verify a participant's medical status. (7-1-25)T

b. Maintain monthly certification statements for review. (7-1-25)T

c. Notify Medicaid when a participant's designated attending physician is not a hospice employee. (7-1-25)T

02. Election Procedures. A participant or their representative must request hospice care by submitting an election statement to a hospice of their choice. (7-1-25)T

a. Elections for hospice care are effective through any subsequent election periods without a break in care when a participant does not change providers or revoke an election. (7-1-25)T

b. A participant who elects less than eight (8) monthly election periods within a benefit period may

request additional election periods available when they meet the following conditions: (7-1-25)T

i. Available hospice days did not exceed two hundred ten (210) days in a benefit period due to loss of financial eligibility; (7-1-25)T

ii. Hospices were not changed excessively; and (7-1-25)T

iii. More than eight (8) election periods were not revoked. (7-1-25)T

c. A participant cannot request an effective date earlier than the date of their election. (7-1-25)T

d. A participant twenty-one (21) years of age or older must waive all rights to Medicaid payments for the duration of an election period of hospice care for services related to their terminal condition except when provided under hospice services. (7-1-25)T

03. Hospice Election. Participant statements must identify their choice of hospice provider and an effective date, acknowledge their informed choice of hospice care and waiver of any non-excepted Medicaid services during hospice benefit periods, and be signed and dated by the participant or their representative. (7-1-25)T

04. Election Revocation. Participants or their representatives may revoke an election at any time by filing a signed statement with the hospice that includes their request to revoke an election of hospice care and an effective date. Medicaid coverage is reinstated upon revocation. (7-1-25)T

05. Hospice Change. Participants may request a change of provider during any eligible election period, but no more than six (6) times during a benefit period. Participants must submit a signed and dated statement to the current provider and the new provider during the monthly election period, that includes the current hospice care provider, new hospice provider requested, and effective date. Changes in provider ownership do not apply. (7-1-25)T

06. Plan of Care. Must be established and reviewed at least monthly and include all covered services and supplies. The basic interdisciplinary group member assessing a patient's needs must confer with at least one (1) other member before writing an initial plan of care. At least one (1) person involved in developing an initial plan must be an RN or physician. Plans must be established on the same day as an assessment to be covered as part of hospice care. The other two (2) basic interdisciplinary group members must review an initial care plan and provide input to the process of establishing the plan within two (2) calendar days following the assessment. (7-1-25)T

655. HOSPICE: PROVIDER QUALIFICATIONS AND DUTIES.

Providers must submit a list of physicians, including volunteer physicians, employed by the hospice in their provider application and update any changes to this list. (7-1-25)T

656. HOSPICE: REIMBURSEMENT.

Except for payment of physician services, Medicaid pays for hospice care under one (1) of five (5) predetermined daily rates depending on type and intensity of services. There are no retroactive rate adjustments other than application of a "cap" on overall payments, a service intensity add-on, and limitations on inpatient care payments. Payment levels include: (7-1-25)T

01. Routine Home Care. Payment includes one (1) of two (2) routine home care rates for each day of residence, under hospice care, and not receiving continuous home care. The rate paid disregarding the volume or intensity of routine services provided any given day. The two-rate payment methodology results in a higher payment for days one (1) through sixty (60) of hospice care and a reduced rate for all subsequent days. If a participant leaves hospice care and later resumes hospice care, regardless of provider, a minimum 60-day gap in hospice services is required for payment of the higher base routine home care rate. If a minimum 60-day gap in hospice services is not met, providers are paid the lower base rate. (7-1-25)T

02. Continuous Home Care. Continuous home care is provided only during crisis periods when a patient requires continuous nursing care to achieve palliation and manage acute medical symptoms. Care must be provided by either an RN or LPN for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a 24-hour day beginning and ending at midnight and does not need to be continuous and

uninterrupted. Less skilled care needed on a continuous basis to enable a person to remain at home is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate is paid to the hospice up to twenty-four (24) hours per day. (7-1-25)T

03. Inpatient Respite Care. Payment is the inpatient respite care rate for each day a participant resides in an approved inpatient facility receiving respite care. Payment for a maximum of five (5) days includes the admission date but not the discharge date in any monthly election period. Payment for the sixth and any subsequent days is made at an appropriate rate: routine, continuous, or general inpatient rate. (7-1-25)T

04. General Inpatient Care. Payments are made for general inpatient care provided. No other fixed payment rates are applicable for a day a participant receives hospice general inpatient care except qualifying physician services. (7-1-25)T

a. An appropriate home care rate is paid for discharge dates unless a patient dies in an inpatient unit. Date of a patient death is considered the discharge date and paid at the inpatient rate. (7-1-25)T

b. Medicaid hospice rates are the same as Medicare hospice rates, adjusted to disregard cost offsets for Medicare coinsurance amounts. No cost sharing is imposed for participants receiving hospice services. (7-1-25)T

c. Medicaid hospice benefits continue after a participant's Medicare hospice benefit expires. The hospice must continue providing care until a patient dies or revokes a hospice care election. (7-1-25)T

05. Service Intensity Add-On. Add-on payments are made for visits by an RN or social worker during the last seven (7) days of life in addition to the routine home care rate, calculated by multiplying the continuous home care rate per fifteen (15) minutes by the number of units for combined daily visits. Payments do not exceed sixteen (16) units per day, are adjusted for geographic wage differences, and do not include a social worker's phone time. (7-1-25)T

657. HOSPICE: INPATIENT PAYMENT LIMITATIONS.

If the Department determines an inpatient rate should not be paid, any days a provider receives payment at a home care rate is not counted as inpatient days. Limitations include: (7-1-25)T

01. Maximum Allowable Inpatient Days. Calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%). If the total amount exceeds the maximum number of allowable inpatient days, a payment limitation is determined by: (7-1-25)T

a. Calculating the ratio of the maximum allowable inpatient days to the number of actual inpatient care days and multiplying the ratio by the total payment for inpatient care made. (7-1-25)T

b. Multiplying excess inpatient care days by the routine home care rate. (7-1-25)T

c. Adding the two (2) calculated amounts and comparing the sum to interim inpatient hospice care payments made during the "cap period." (7-1-25)T

02. Limitation Cap. When any interim payments for inpatient care exceed the limitation, a provider must return the amount over the limitation. (7-1-25)T

658. HOSPICE: PHYSICIAN PAYMENTS.

Basic hospice care rates represent full payment to the provider for all costs of covered services, including administrative and general activities performed by physicians employed by or working under a hospice. (7-1-25)T

01. Hospice Employed Physicians. Payment for direct patient services is made under the Medicaid rate methodology for physician services and related payments are counted in the overall hospice cap. Providers may only bill for physician's direct patient care services. Laboratory and X-ray services are included in the hospice daily rate. (7-1-25)T

02. Volunteer Physicians. Volunteer services are excluded from Medicaid payment except when the

hospice is reimbursed on behalf of a volunteer physician for specific direct patient care services not rendered on a volunteer basis, and a hospice must reimburse a physician for services rendered. A physician must not provide voluntary services based on a patient's ability to pay. (7-1-25)T

03. Independent Physicians. These services are reimbursed outside of the hospice benefit. Laboratory or X-ray services are excluded and must be provided by the hospice. (7-1-25)T

659. HOSPICE: REIMBURSEMENT CAP.
Aggregate payments to each hospice are limited during a hospice cap period. Total payments made for services during this period are compared to the "cap amount" for each period. Providers must return any payments more than the cap. (7-1-25)T

01. Overall Cap. The cap is compared to reimbursement after computing the inpatient limitation and subtracting from the total reimbursement amount. (7-1-25)T

02. Total Payment. All payments for services rendered during a cap year, regardless of when payment is made. (7-1-25)T

03. Calculation of Cap. "Cap amount" is calculated by multiplying the number of participants of hospice care during the period by an amount adjusted for each cap year reflecting the percentage change in the medical care expenditure category of the Consumer Price Index for all urban consumers as published by the U.S. Bureau of Labor and Statistics. (7-1-25)T

04. Number of Participants. Providers must report the number of Medicaid participants receiving hospice care during each period to the Department within thirty (30) days after the end of a cap period. For participants transferred to a non-certified hospice where no payment is made to the non-certified hospice, the certified provider may count a complete participant benefit period in their cap amount. (7-1-25)T

05. Certified Mid-Month. A weighted average cap amount based on the number of days falling within each cap period is used. (7-1-25)T

06. Adjustment to Overall Cap. Amounts in each hospice's cap period are adjusted to reflect changes in the cap periods and designated hospices during a participant's election period. The proportion of each hospice's service days to the total number of hospice days rendered to a participant during an election period is multiplied by the cap amount to determine an adjusted cap amount. (7-1-25)T

a. Each hospice's adjusted cap amount is computed as follows: (7-1-25)T

i. The share of the "cap amount" allowed by each hospice is based on the proportion of total covered days provided by each hospice in a "cap period." (7-1-25)T

ii. The maximum number of allowable inpatient days for each certified hospice is multiplied by the "cap amount" specified for the "cap period" in which the participant first elected hospice. (7-1-25)T

b. The participant must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year for it to count as an election during the current cap year. (7-1-25)T

07. Additional Amount for NF Residents. Additional per diem amounts are paid for "room and board" of hospice residents in a NF who receive routine or continuous care services. Room and board include all assistance with ADLs, socializing activities, medication administration, maintaining cleanliness of resident rooms, and supervising and assisting use of DME and prescribed therapies. Additional payments are not subject to payment caps. Room and board rates are ninety-five percent (95%) of per diem interim rates assigned to a facility for the dates a participant resides in a NF. (7-1-25)T

660. HOSPICE: PATIENT LIABILITY.
The Department reduces payments for the hospice benefit, including supplementary room and board amounts, by an

amount determined during the participant eligibility process. (7-1-25)T

661. – 959. (RESERVED)

DUAL ELIGIBLES
(Sections 960 - 979)

SUB AREA: MEDICARE SAVINGS PROGRAM
(Sections 960-969)

960. MEDICARE SAVINGS PROGRAM.

01. AABD Effective Date. Effective date for participants approved for Medicaid and AABD cash is the first month of AABD cash eligibility. (7-1-25)T

02. SSI Effective Date. Effective date for participants approved for Medicaid who also receive SSI, but not AABD cash, is the first month of Medicaid eligibility. (7-1-25)T

03. Neither AABD nor SSI Effective Date. Effective date for participants approved for Medicaid who do not receive AABD cash or SSI is the third month of Medicaid eligibility. (7-1-25)T

961. – 969. (RESERVED)

SUB AREA: MEDICARE/MEDICAID COORDINATED PLAN (MMCP)
(Sections 970-979)

970. MANAGED CARE FOR DUALS.
Medicaid benefit plan, referred to collectively as the Medicare/Medicaid Coordinated Plan (MMCP), for dual-eligible participants to enroll in a managed care organization (MCO) offering Idaho Medicaid Plus (IMPlus) or MMCP health plans. (7-1-25)T

971. MANAGED CARE FOR DUALS: DEFINITIONS.

01. Dual Eligible. Participants with enhanced plan benefits, except those from Breast and Cervical Cancer eligibility, who are also enrolled in both Medicare Parts A and B. (7-1-25)T

02. Evidence of Coverage. Contract between an MCO and the participant detailing covered services. (7-1-25)T

03. Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP). Health plan option that fully integrates Medicare and Medicaid benefits under a single MAO. (7-1-25)T

04. Idaho Medicaid Plus (IMPlus). MMCP health plan option where most Medicaid covered services are provided by one MCO. (7-1-25)T

05. Medicare Advantage Organizations (MAOs). MCO approved by CMS to offer Medicare Advantage Plans. (7-1-25)T

06. Medicare Advantage Plan. Private health plans contracted with CMS to provide Medicare Parts A, B, and D benefits. (7-1-25)T

07. Medicare/Medicaid Coordinated Plan (MMCP). MMCP health plan option integrating Medicare and Medicaid covered services under a FIDE-SNP provided by one MCO. (7-1-25)T

08. Passive Enrollment. Process where the Department assigns a participant to an IMPlus plan unless the participant actively enrolls in MMCP or opts out of IMPlus. (7-1-25)T

972. MANAGED CARE FOR DUALS: PROGRAM AUTHORITY.
MCOs seeking to offer IMPlus and/or MMCP health plans operate under Department contract and appropriate CMS approval. (7-1-25)T

01. IMPlus. CMS approval of MCO under 1915(b) authority. (7-1-25)T

02. MMCP. CMS approval of MAO to operate a Medicare Advantage Plan. (7-1-25)T

973. MANAGED CARE FOR DUALS: ELIGIBILITY AND ENROLLMENT.
Only dual eligible participants over age twenty-one (21) may enroll in IMPlus or MMCP plans. Enrollment requirements vary by county. (7-1-25)T

01. Exclusions. Individuals receiving Adult DD 1915(c) waiver benefits are excluded from IMPlus enrollment. (7-1-25)T

02. Exemptions. Tribal members and pregnant women are exempt from mandatory enrollment requirements but may voluntarily enroll in MMCP plan options when available in their county of residence and retain the right to disenroll at any time. (7-1-25)T

03. Voluntary Counties. Participants residing in a county with at least one (1) participating MCO may voluntarily enroll in MMCP under an available IMPlus or MMCP plan and may terminate from a plan at any time. Coverage continues until the end of the month of termination. Once disenrolled, MMIS reenrolls participants under fee-for-service Medicaid. (7-1-25)T

04. Mandatory Counties. Participants without an exclusion and residing in a county with two (2) or more active MCOs must enroll in either an IMPlus or MMCP plan. The Department assigns participants who fail to choose a plan into an IMPlus MCO. (7-1-25)T

05. Passive Counties. The Department enrolls participants without an exclusion and residing in a county with only one (1) participating MCO into the MCO's IMPlus plan unless they enroll in the MCO's MMCP plan or opt out by contacting the Department. These participants may opt out of IMPlus at any time. (7-1-25)T

974. MANAGED CARE FOR DUALS: COVERAGE AND LIMITATIONS.

01. Coverage. All MMCP plan options include Medicaid-only Basic and Enhanced Plan services provided by Medicaid providers that are not MAOs. Medicaid may cover additional services not included in the MCO's Evidence of Coverage. MAOs providing MMCP plans may limit or expand MAO-covered services, including Medicare Parts A, B, and D benefits or supplemental services unavailable on Medicaid or Medicare, as detailed in the contract and Evidence of Coverage. (7-1-25)T

02. Limitations. Services not included in the Evidence of Coverage are carved out and provided under fee-for-service Medicaid or other contracted entities. (7-1-25)T

975. – 979. (RESERVED)

INVESTIGATIONS, AUDITS, AND ENFORCEMENT
(Sections 980 - 999)

SUB AREA: LIENS AND ESTATE RECOVERY
(Sections 980-989)

980. (RESERVED)

981. LIENS AND ESTATE RECOVERY: DEFINITIONS.

01. Adequate Consideration. An act, object, services, or other benefit which has a tangible and/or intrinsic value that is equivalent to or greater than the fair market value of the transferred asset. (7-1-25)T

02. Authorized Representative. The person appointed by the court as the personal representative in a probate proceeding or the person identified by the participant to receive notice and make decisions on estate matters. (7-1-25)T

03. Discharge From a Medical Institution. A medical decision made by a competent provider that the participant no longer needs nursing home care because the participant's condition has improved, or the discharge is not medically contraindicated. (7-1-25)T

04. Home. The dwelling in which the participant has an ownership interest, and which the participant occupied as their primary dwelling prior to, or subsequent to, their admission to a medical institution. (7-1-25)T

05. Institutionalized Participant. An inpatient in a NF, ICF/IID, or other medical institution, who is a Medicaid participant subject to post-eligibility treatment of income in IDAPA 16.03.05. (7-1-25)T

06. Lawfully Residing. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. (7-1-25)T

07. Permanently Institutionalized. An institutionalized participant of any age who the Department has determined cannot reasonably be expected to be discharged from the institution and return home. Discharge refers to a medical decision made by a competent provider that the participant is physically able to leave the institution and return to live at home. (7-1-25)T

08. Personal Property. Any property that is not real property, including cash, jewelry, household goods, tools, life insurance policies, boats, and wheeled vehicles. (7-1-25)T

09. Real Property. Any land, including buildings or immovable objects attached permanently to the land. (7-1-25)T

10. Residing in the Home on a Continuous Basis. Occupying and continuing to occupy the home as the primary residence. (7-1-25)T

11. Termination of a Lien. The release or dissolution of a lien from property. (7-1-25)T

12. Undue Hardship. Conditions that justify waiver or deferral of all or a part of the Department's claim against an estate. (7-1-25)T

13. Undue Hardship Waiver. A decision made by the Department to relinquish, limit, or defer its claim to any or all estate assets of a deceased participant based on good cause. (7-1-25)T

982. LIENS AND ESTATE RECOVERY: NOTIFICATION TO DEPARTMENT.

All notification regarding liens, estate claims, and requests for notice must be directed to the Department of Health and Welfare, Estate Recovery Unit, 450 W. State Street, 6th Floor, Boise, Idaho 83702. (7-1-25)T

983. LIENS AND ESTATE RECOVERY: LIEN DURING LIFETIME OF PARTICIPANT.

01. Lien Imposed During Lifetime of Participant. During the lifetime of the permanently institutionalized participant, except as noted, the Department may impose a lien against the real property of the participant for medical assistance correctly paid on their behalf. The lien must be filed within ninety (90) days of the Department's final determination, after notice and opportunity for a hearing, that the participant is permanently institutionalized. The lien is effective from the beginning of the most recent continuous period of the participant's institutionalization. Any lien imposed will dissolve upon the participant's discharge from the medical institution and return home. (7-1-25)T

02. Determination of Permanent Institutionalization. The Department must determine that the participant is permanently institutionalized prior to the lien being imposed. An expectation or plan that the participant will return home with the support of HCBS does not, in and of itself, justify a decision that they are reasonably

expected to be discharged to return home. The following factors must be considered when making the determination of permanent institutionalization: (7-1-25)T

a. The participant must meet the criteria for NF or ICF/IID level of care and services; (7-1-25)T

b. The medical records must be reviewed to determine if the participant's condition is expected to improve to the extent that they will not require NF or ICF/IID level of care; and (7-1-25)T

c. Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. (7-1-25)T

03. Notice of Determination of Permanent Institutionalization and Hearing Rights. The Department must notify the participant or their authorized representative, in writing, of its intention to decide that the participant is permanently institutionalized, and that they have the right to a fair hearing. This notice must inform the participant of the following information, at a minimum: (7-1-25)T

a. The Department's decision that they cannot reasonably be expected to be discharged from the medical institution to return home is based upon a review of the medical records and plan of care, but that this does not preclude them from returning home with services necessary to support NF or ICF/IID level of care; and (7-1-25)T

b. They or their authorized representative may request a fair hearing prior to the Department's final determination that they are permanently institutionalized. The notice must include information that a pre-hearing conference may be scheduled prior to a fair hearing. The notice must include the time limits and instructions for requesting a fair hearing. (7-1-25)T

c. If they or their authorized representative does not request a fair hearing within the time limits specified, their real property, including their home, may be subject to a lien, except as noted. (7-1-25)T

04. Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Participant. Should the property upon which a lien is imposed be sold, the Department will seek recovery of all medical assistance paid on behalf of the participant, except as noted. Recovery of the medical assistance paid on behalf of the participant from the proceeds from the sale of the property does not preclude the Department from recovering additional medical assistance paid from the participant's estate. (7-1-25)T

05. Filing of Lien During Lifetime of Participant. When appropriate, the Department will file, in the office of the Recorder of the county in which the real property of the participant is located, a verified statement, in writing, setting forth the following: (7-1-25)T

a. The name and last known address of the participant; and (7-1-25)T

b. The name and address of the official or agent of the Department filing the lien; and (7-1-25)T

c. A brief description of the medical assistance received by the participant; and (7-1-25)T

d. The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as medical assistance benefits are paid on behalf of the participant. (7-1-25)T

06. Renewal of Lien Imposed During Lifetime of Participant. The lien, or any extension thereof, must be renewed every five (5) years by filing a new verified statement, or as required by Idaho law. (7-1-25)T

07. Termination of Lien Imposed During Lifetime of Participant. The lien will be released as provided by Idaho Code, upon satisfaction of the Department's claim. The lien will dissolve in the event of the participant's discharge from the medical institution and return home. Such dissolution of the lien does not discharge the underlying debt, and the estate remains subject to recovery under estate recovery provisions under this rule. (7-1-25)T

984. LIENS AND ESTATE RECOVERY: REQUIREMENTS FOR ESTATE RECOVERY.

01. Recovery From Estate of Spouse. Recovery from the estate of the spouse of a Medicaid participant may be made as permitted in Sections 56-218 and 56-218A, Idaho Code. (7-1-25)T

02. Lien Imposed Against Estate of Deceased Participant. Liens may be imposed against the estates of deceased Medicaid participants and their spouses as permitted by Section 56-218, Idaho Code. (7-1-25)T

03. Notice of Estate Claim. The Department will notify the authorized representative of the amount of the estate claim after the death of the participant, or after the death of the surviving spouse. The notice must include instructions for applying for an undue hardship waiver. (7-1-25)T

04. Assets in Estate Subject to Claims. Assets in the estate from which the claim can be satisfied must include all real or personal property that the deceased participant owned or in which they had an ownership interest, including the following: (7-1-25)T

a. Payments to the participant under an installment contract will be included among the assets of the deceased participant. This includes an installment contract on any real or personal property to which the deceased participant had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the participant. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt.(7-1-25)T

b. The deceased participant's ownership interest in another person’s estate, probated or not probated, is an asset of their estate when: (7-1-25)T

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or (7-1-25)T

ii. The deceased participant received income from property of another person; or (7-1-25)T

iii. State intestacy laws award the deceased participant a share in the distribution of the property of another estate. (7-1-25)T

c. Any trust instrument that is designed to hold or to distribute funds or property, real or personal, in which the deceased participant had a beneficial interest is an asset of the estate. (7-1-25)T

d. Life insurance is considered an asset when it has reverted to the estate. (7-1-25)T

e. Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. Any funds remaining after payment to the funeral home will be considered assets of the estate. (7-1-25)T

f. Checking and savings accounts that hold and accumulate funds designated for the deceased participant are assets of the estate, including joint accounts that accumulate funds for the benefit of the participant. (7-1-25)T

g. In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a participant prior to their death, absent evidence to the contrary, such funds are an asset of the deceased participant's estate, even if a court has to approve release of the funds. (7-1-25)T

h. Shares of stocks, bonds, and mutual funds to the benefit of the deceased participant are assets of the estate. (7-1-25)T

05. Value of Estate Assets. The Department will use fair market value as the value of the estate assets. (7-1-25)T

985. LIENS AND ESTATE RECOVERY: LIMITATIONS AND EXCLUSIONS.

01. Limitations on Estate Claims. Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. (7-1-25)T

02. Expenses Deducted From Estate. The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim: (7-1-25)T

a. Funeral expenses reasonably necessary for burial or cremation services approved on a case-by-case basis at the discretion of the Department. (7-1-25)T

b. Administrative expenses of the estate may be deducted in accordance with Section 56-218, Idaho Code. (7-1-25)T

03. Interest on Claim. The Department's claim does not bear interest until the claim becomes recoverable. Interest on the claim accrues at the legal rate of interest. (7-1-25)T

04. Excluded Land. Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. (7-1-25)T

05. Certain Life Estates. The value of a life estate owned by a Medicaid participant, or their spouse will not be subject to estate recovery if: (7-1-25)T

a. Neither the Medicaid participant or their spouse ever owned the remainder interest; or (7-1-25)T

b. The life estate was created prior to July 1, 1995. (7-1-25)T

06. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement or other such agreement that separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. (7-1-25)T

07. Undue Hardship Exception. It is not considered undue hardship when family members anticipate or expect an inheritance or will be inconvenienced economically by the lack of an inheritance. (7-1-25)T

a. An applicant for an undue hardship waiver must be family with a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. (7-1-25)T

b. Undue hardship waivers will be considered in the following circumstances: (7-1-25)T

i. The estate subject to recovery is income-producing property that provides the sole source of support for heirs; or (7-1-25)T

ii. Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or (7-1-25)T

iii. The Department's claim is less than five hundred dollars ($500) or the total assets of the entire estate are less than five hundred dollars ($500), excluding trust accounts or other bank accounts. (7-1-25)T

c. Any claim may be waived or deferred by the Department, partially or fully, because of undue

hardship. An undue hardship does not exist if action taken by the participant prior to their death, or by their legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case-by-case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery. (7-1-25)T

08. Set Aside of Transfers. Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether the asset transfer resulted, or could have resulted, in a period of ineligibility. (7-1-25)T

986. LIENS AND ESTATE RECOVERY: REQUEST FOR NOTICE.

01. Notice - Hearing. The Department must notify the participant or their authorized representative, in writing, of its intention to record a request for notice, and that they have the right to a fair hearing. The notice must inform the participant of the following information: (7-1-25)T

a. The Department's determination that they are the record titleholder or purchaser under a land sale contract of real property subject to a request for notice; (7-1-25)T

b. They or their authorized representative may request a fair hearing prior to the Department's recording a request for notice. The notice must include the time limits and instructions for requesting a fair hearing; and (7-1-25)T

c. If they or their authorized representative do not request a fair hearing within the time limits specified, a request for notice applying to their real property, including their home, may be recorded. (7-1-25)T

02. Forms - Content. The notices must include the following information: (7-1-25)T

a. The name of the public assistance recipient and the spouse of such public assistance recipient, if any; (7-1-25)T

b. The Medicaid number for the public assistance recipient and spouse, if any; (7-1-25)T

c. The legal description of the real property affected or to be affected; (7-1-25)T

d. The mailing address at which the Department is to receive notice; (7-1-25)T

e. If the document is a Notice of Transfer or Encumbrance, the name and address of the transferee or lien holder; and (7-1-25)T

f. A fully executed acknowledgment as required for recording under Section 55-805, Idaho Code. (7-1-25)T

03. Webpages for Forms. These forms may be found at http://healthandwelfare.idaho.gov. (7-1-25)T

a. Notice of Transfer or Encumbrance. (7-1-25)T

b. Request for Notice. (7-1-25)T

c. Termination of Request for Notice. (7-1-25)T

987. – 989. (RESERVED)

SUB AREA: PARTICIPANT LOCK-IN
(Sections 990 - 999)

990. PARTICIPANT UTILIZATION CONTROL PROGRAM.
This Program is to promote improved and cost-efficient medical management of essential health care by monitoring

participant activities and taking action to correct abuses. Participants demonstrating unreasonable patterns of utilization or exceeding reasonable levels of utilization will be reviewed for restriction. The Department may require a participant to designate a primary provider or a single pharmacy for exclusive provider services to protect the individual's health and safety, provide continuity of medical care, avoid duplication of services by providers, avoid inappropriate or unnecessary utilization of medical assistance. (7-1-25)T

991. LOCK-IN DEFINED.
Lock-in is the process of restricting the access of a participant to a specific provider or providers. (7-1-25)T

992. DEPARTMENT EVALUATION FOR LOCK-IN.
The Department will determine if services are being utilized at a frequency or amount that is not medically necessary. Evaluations can include review of medical records or computerized reports reflecting claims. (7-1-25)T

993. CRITERIA FOR LOCK-IN.
There are no specific criteria for lock-in as each case is unique. The Department may develop non-binding guidelines for purposes of uniformity. The following utilization patterns may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or over utilization of Medicaid services, and may result in the restriction of Medicaid reimbursement for a participant to a single provider or providers: (7-1-25)T

01. Unnecessary Use of Providers or Services, Including Excessive Provider Visits. (7-1-25)T

02. Demonstrated Abusive Patterns. Recommendation from a provider that the participant has demonstrated abusive patterns and would benefit from the lock-in program. (7-1-25)T

03. Use of Emergency Room. Frequent use of emergency room for non-emergent conditions. (7-1-25)T

04. Multiple Providers. (7-1-25)T

05. Controlled Substances. (7-1-25)T

06. Use of Multiple Prescribing Providers or Pharmacies. (7-1-25)T

07. Overlapping Prescription Drugs With the Same Therapeutic Classes. (7-1-25)T

08. Drug Abuse. (7-1-25)T

09. Drug-Seeking Behavior. As identified by a provider. (7-1-25)T

10. Other Abusive Utilization. As determined by the Department's medical or pharmacy consultant. (7-1-25)T

994. LOCK-IN PARTICIPANT NOTIFICATION.
A participant designated by the Department for the Participant Utilization Control Program will be notified in writing by the Department of the action and the participant's right of appeal by means of a fair hearing. (7-1-25)T

995. LOCK-IN PROCEDURES.

01. Participant Responsibilities. The participant will be given thirty-five (35) days to contact the Regional Program Manager and complete and sign the lock-in agreement form and select designated provider(s) in each area of misuse. (7-1-25)T

02. Appeal Stays Restriction. The Department will not implement the participant restriction if a valid appeal is noted. (7-1-25)T

03. Lock-In Duration. The Department will restrict participants to their designated providers for a period determined by the Department. Upon review at the end of that period, lock-in may be extended for an

additional period determined by the Department. (7-1-25)T

04. Payment to Providers. Payment to providers other than the designated lock-in provider or pharmacy is limited to documented emergencies or referrals. (7-1-25)T

05. Regional Programs Manager. The Regional Programs Manager will: (7-1-25)T

a. Clearly describe the participant's appeal rights; (7-1-25)T

b. Specify the effective date and length of the restriction; (7-1-25)T

c. Have the participant choose a designated provider or providers; and (7-1-25)T

d. Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the participant's Medicaid services will be immediately restricted to the designated providers. (7-1-25)T

996. PENALTIES FOR LOCK-IN NONCOMPLIANCE.
If a participant fails to respond to the notification of medical restrictions, fails to sign the lock-in agreement, or fails to select a primary provider within the specified period, the Medicaid benefits will be restricted to documented emergencies only. If a participant continues to abuse or over-utilize items or services after being identified for lock-in, the Department may terminate Medicaid benefits for a specified period as determined by the Department. (7-1-25)T

997. APPEAL OF LOCK-IN.
Department determinations to lock-in a participant may be appealed. (7-1-25)T

998. RECIPIENT EXPLANATION OF MEDICAID BENEFITS (REOMBS).

01. Participant Response. A participant is required to respond to the Department's explanation of medical benefits survey whenever they are aware of discrepancies. (7-1-25)T

02. Participant Unable to Respond. If the participant is unable, because of medical or physical limitations, to respond to the survey personally, then a responsible family member or friend can respond on their behalf. (7-1-25)T

999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.17 – RESIDENTIAL HABILITATION AGENCIES

DOCKET NO. 16-0417-2501 (ZBR CHAPTER REPEAL)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 56-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 18th, 2025.

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

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

This chapter is proposed to be repealed and consolidated into Docket No. 16-0321-2501. Consolidating these two chapters will assist the Department and providers with efficiency and consistency while reducing regulatory burden and ensure the health and safety of the vulnerable individuals these organizations serve. This chapter includes requirements for Adult Residential Care Facilities that provides residential services to adult individuals with developmental disabilities.

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

Fees will not be increased as a result of this rulemaking.

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

There is not anticipated to be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, Volume 25-4, pages 27 and 28.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.idaho.gov. Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25th, 2025.

DATED this 2nd day of May, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
DHWRules@dhw.idaho.gov

IDAPA 16.04.17 IS PROPOSED TO BE REPEALED IN ITS ENTIRETY.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.05.01 – USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-2501 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 39-242, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code.

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

VIRTUAL TELECONFERENCES Via WebEx
Monday, June 9, 2025 **9:00 AM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m65eaa06a89c8aa696eed4edb88030ae2** **Join by meeting number** **Meeting number (access code): 2821 862 0443** **Meeting password: gRwyUApY754** **Meeting password when dialing from a phone or video system: 47998279** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Wednesday, June 18, 2025 **11:00 AM (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mb80e43040b27d406537522a26cb40aa1** **Join by meeting number** **Meeting number (access code): 2823 759 0089** **Meeting password: JutVPKwE949** **Meeting password when dialing from a phone or video system: 58887593** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

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

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

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Fees will not be increased as a result of this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: There is not anticipated to be a negative fiscal impact exceeding $10,000.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 2nd, 2025 Idaho Administrative Bulletin, Volume 25-4, pages 29 and 30.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jared Larsen at DHWRules@dhw.idaho.gov.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25th, 2025.

DATED this 2nd day of May, 2025.

Jared Larsen
Chief, Legislative and Regulatory Affairs
Idaho Department of Health & Welfare
450 W. State Street, 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500 phone; (208) 334-6558 fax
DHWRules@dhw.idaho.gov

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0501-2501
(ZBR Chapter Rewrite)

16.05.01 – USE AND DISCLOSURE OF DEPARTMENT RECORDS

000. LEGAL AUTHORITY.
Sections 39-242, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code. (7-1-25)

001. SCOPE.
These rules govern the use and disclosure of information maintained by the Department, in compliance with applicable state and federal laws, and federal regulations. (7-1-25)

002. -- 0~~06~~10. (RESERVED)

007. DISTRICT COURT APPEALS, COMPLAINTS AND REQUESTS FOR RECONSIDERATION.
The confidentiality of health information is defined in part by the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC 1320d, 110 Statutes at Large 2033-4, and 45 CFR Sections 160 and 164. (3-17-22)

01. Appeals to District Court. Anyone who is aggrieved by a denial of disclosure or amendment of a public record may file an appeal in the appropriate district court in compliance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. (3-17-22)

02. Complaints to Privacy Officer. Individuals who are dissatisfied with a Department decision regarding confidential information may file a written complaint with the Department's Privacy Officer. Complaints must be submitted to the Department's Privacy Officer at the mailing address for the Department's business office. The Privacy Officer determines if a complaint is valid and makes a recommendation for its resolution to the Department within twenty-eight (28) days after the complaint is received. (3-17-22)

a. Secretary of Health and Human Services (HHS). Complaints that involve the use and disclosure of health information may also be submitted to the Secretary of Health and Human Services at the following address: The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. (3-17-22)

b. Time for filing complaints. Complaints must be filed within one hundred eighty (180) days from the date of the alleged violation. (3-17-22)

03. Request for Reconsideration to Access Health Information. The individual or legal representative may submit a written request for reconsideration to the Privacy Officer if access to health information is denied. (3-17-22)

a. The request for reconsideration must be postmarked no later than twenty-eight (28) days after notice of the denial was mailed. (3-17-22)

b. The reconsideration will be conducted by another licensed health care professional who did not participate in the original decision. (3-17-22)

c. The Department will notify the individual of the outcome of the review within twenty-eight (28) days after the request is received. (3-17-22)

008. -- 009. (RESERVED)

010. DEFINITIONS.

01. Authorization. A time limited written consent for the disclosure of confidential information to a specific individual or entity outside the Department, and outside of normal business processes for providing Department services. (3-17-22)

02. Confidential Information. Information that may only be used or disclosed as provided by state or federal law, federal regulation, or state rule. (3-17-22)

03. Consent. Permission to use or disclose confidential information. Consent may be inferred from the circumstances. (3-17-22)

04. Department. The Idaho Department of Health and Welfare. (3-17-22)

05. Guardian ad Litem. The person appointed by the court, according to law, to protect the interest of a minor or an incompetent in a case before the court. (3-17-22)

06. Health Information. Identifying information about the past, present or future: (3-17-22)

~~a. Physical or mental health or condition of an individual; (3-17-22)~~

~~b. Provision of health care to an individual; or (3-17-22)~~

~~c. Payment for health care for an individual. (3-17-22)~~

~~07. Identifying Information. The name, address, social security number, or other information by which an individual could be identified. Information may also be identifying without a name, based on the context or circumstances of a disclosure. (3-17-22)~~

~~08. Informal Representative. A person who is not a legal representative, but who is a relative, friend, or other person permitted to communicate with the Department on behalf of an individual. The individual or legal representative may give such permission verbally, in writing, or through their conduct. (3-17-22)~~

~~09. Legal Representative. The parent of a minor, a guardian, conservator, attorney, or an individual who has an appropriate power of attorney. (3-17-22)~~

~~10. Minimally Necessary. The information that is essential to provide benefits or services, and to perform normal business processes of the Department. (3-17-22)~~

~~11. Need to Know. Confidential information that is necessary to provide benefits or services, and to perform normal business processes of the Department. (3-17-22)~~

~~12. Psychotherapy Notes. Notes recorded in any format by a mental health professional that documents or analyzes the content of individual or group counseling sessions, and that are separated from the rest of the individual's medical record. The term "psychotherapy notes" excludes: (3-17-22)~~

~~a. Medication prescription and monitoring; (3-17-22)~~

~~b. Counseling session start and stop times; (3-17-22)~~

~~c. Types and frequencies of treatment furnished; (3-17-22)~~

~~d. Results of clinical tests; and (3-17-22)~~

~~e. Any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. (3-17-22)~~

011. DEFINITIONS FOR VITAL STATISTICS.
The definitions provided in Subsection 011 of these rules apply to Vital Statistics and to the disclosure provisions of Section 39-270, Idaho Code. (3-17-22)

01. Authorized Representative. An attorney, physician, funeral director, a legally designated agent, or an entity whose purpose for obtaining a vital record is to pay direct benefits to a person with a direct and tangible interest ~~defined in Subsection 011.03 of this rule~~. ~~(3-17-22)~~( )

~~02. Certificate. A certificate of birth, death, stillbirth, miscarriage, marriage, or divorce, filed pursuant to law, excluding information contained in the statistical section of any record. (3-17-22)~~

0~~3~~2. **Individuals with a Direct and Tangible Interest**. Individuals who have a direct and tangible interest in a vital record are: (3-17-22)

a. The registrant and that person's spouse, children, parents, grandparents, grandchildren, siblings, or guardian; (3-17-22)

b. Any other person who demonstrates that the record is needed for the determination or protection of that person's property right; (3-17-22)

c. An authorized representative of any of these individuals; (3-17-22)

d. The surviving next-of-kin if a deceased registrant has no other surviving family member listed in this subsection; (3-17-22)

e. The Idaho Attorney General, and state and federal prosecuting attorneys, if such attorney submits an affidavit affirming that the record is necessary in the furtherance of the attorney's official law enforcement duties, is not reasonably available from another source, and that reasonable steps will be taken to preserve the confidentiality of the record; (3-17-22)

f. Any person, upon the order of an Idaho court of competent jurisdiction, where the court finds that disclosure of the record is necessary in the interests of justice; and (3-17-22)

g. Any person with the right to control the disposition of remains of a deceased person or to determine provisions not clearly covered in a prearranged funeral plan as authorized in Section 54-1142(1) Idaho Code, in accordance with Section 39-270(b), Idaho Code. (3-17-22)

043. Parent. Does not include ~~a biological parent~~ an individual whose parental rights have been terminated with respect to a specific child. ~~(3-17-22)~~( )

054. Public Health. The science and ~~art~~ practice of: ~~(3-17-22)~~( )

a. Preventing disease, prolonging life, or promoting health ~~and efficiency through organized community effort for the sanitation of the environment~~ within populations and communities; ~~(3-17-22)~~( )

b. ~~The c~~Control of communicable infections; ~~(3-17-22)~~( )

c. ~~The e~~Education of the individual in ~~personal hygiene~~ healthy choices; ~~(3-17-22)~~( )

d. ~~The organization of medical and nursing services for the~~Promotion of early diagnosis and ~~preventive treatment~~ prevention of disease; and ~~(3-17-22)~~( )

e. The ~~development of the social machinery to~~ overall support and participation in systems that ensure everyone a standard of living ~~adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize their birthright of~~ to maintain health and longevity. ~~(3-17-22)~~( )

~~**06. Putative Father**. The biological father of a child as identified by himself, the natural mother, an adoption agency, or a court.~~ ~~(3-17-22)~~

~~**07. Registrar**. The state Registrar as defined in Section 39-241(18), Idaho Code. The mailing and street address for the state Registrar is Bureau of Vital Records and Health Statistics, 450 W. State St., 1st Floor, PO Box 83720, Boise, Idaho 83720-0036.~~ ~~(3-17-22)~~

085. Research. Organized scientific inquiry or examination of data in order to discover and interpret facts. (3-17-22)

096. Statistical Purposes. The collection, analysis, interpretation and presentation of masses of non-identifying numerical information. (3-17-22)

012. --~~049.~~ ~~(RESERVED)~~

~~GENERAL CONSENT AND DISCLOSURE REQUIREMENTS (Sections 050-199)~~

~~050. CONSENT TO GATHER, USE AND DISCLOSE INFORMATION.~~
~~When individuals, legal representatives or informal representatives sign an application, they consent for the~~

Department to gather, use and disclose information as needed for an individual to receive Department benefits or services. If none of these individuals provides a consent on an application, service may be denied. An informal representative may only consent to the disclosure of confidential information when permitted by these rules. (3-17-22)

051. AUTHORIZATION FOR THE USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION.
An authorization for the use and disclosure of confidential information must be in writing, and identify the individual who is the subject of the record. (3-17-22)

01. Content of Authorization. An authorization must be dated and signed by the individual or legal representative, and: (3-17-22)

a. Identify the specific information involved; (3-17-22)

b. State the duration of the authorization, defined by a specific date or the description of an event; (3-17-22)

c. Identify the recipient of the information; and (3-17-22)

d. State the purpose for the authorization, or state that it is, "At the request of the individual," or similar wording. (3-17-22)

02. Defective Authorization. An authorization must not be acted upon if the authorization has expired or has been revoked, or if any essential information is omitted or is false. (3-17-22)

03. Authorization for the Use and Disclosure of Health Information. An authorization for the use and disclosure of health information must contain the content listed in Subsection 051.01 and the statements required by 45 CFR 164.508(c)(2). (3-17-22)

04. Psychotherapy Notes. Psychotherapy notes that are separate from the rest of an individual's record may not be used or disclosed without an authorization except to the originator of the notes for treatment or to defend the Department in a legal action brought by the individual. (3-17-22)

05. Revocation of an Authorization. An individual or legal representative may revoke an authorization at any time by submitting a written request at any Department office. (3-17-22)

06. Effect on Benefits and Services. An individual's refusal to provide an authorization does not affect the receipt of benefits or services the individual would otherwise receive. (3-17-22)

07. Copy of Authorization. The Department will provide a copy of the signed authorization to the individual or legal representative. (3-17-22)

052. – 074. (RESERVED)

075. USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION.
Without a consent or an authorization, no one may use or disclose health or other confidential information except as provided in Section 100 of this chapter. With a consent or an authorization, confidential information will be used or disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the Department's business and the provision of benefits or services, subject to law and the exceptions listed in these rules. Recipients of information must protect against unauthorized disclosure or use of the information for purposes that are not specified in a consent or an authorization. Access to an individual's own records is governed by Section 125 of this chapter. Specific consent and disclosure requirements are identified in Sections 200 through 283 of these rules. (3-17-22)

01. Identity. Any individual who requests to review, copy, restrict or amend confidential information, or to sign an authorization, must provide verification of identity, and where appropriate, present proof that the individual is a legal representative of the subject of the record. Except for verifications or requests for certified copies of vital records, requests submitted by mail must be notarized if necessary to identify the individual's signature.

(3-17-22)

02. Order of Court or Hearing Officer. If information is subpoenaed in a civil, criminal or administrative action, the Department will provide such information as would be disclosed with a public records request, without an order from the court or hearing officer. Alternatively, the Department may submit the record with a request for a review solely by the judge or hearing officer, and an order appropriately limiting its use by the parties. If Department staff have reason to believe that release of a record through a public records request may be detrimental to any individual, the Department may seek a protective order. (3-17-22)

03. Referent. Unless the individual is a witness in litigation, identifying information must not be disclosed about an individual who reported concerns relating to any Department responsibility, including: (3-17-22)

a. Fraud; (3-17-22)

b. Abuse, neglect or abandonment of a child; (3-17-22)

c. Abuse, neglect or abandonment of a vulnerable adult; (3-17-22)

d. Concerns about the mental health of another; and (3-17-22)

e. Certified family homes, unless the complainant consents to disclosure in writing or disclosure is required in any administrative or judicial proceeding, in compliance with Section 74-105(16), Idaho Code. (3-17-22)

04. Collateral Contact. Identifying information must not be disclosed about individuals who are not the subject of the record and who provide information to the Department in the ordinary course of business. (3-17-22)

05. Alternative Communication. The Department, contractors and providers must comply with an individual's request that confidential information be communicated by alternative means of delivery unless it is administratively difficult to do so or the request is unreasonable. If approved, all information from a Department program will use the same alternative means of delivery after the request is received and recorded. (3-17-22)

06. Restriction on Disclosure of Health Information. (3-17-22)

a. An individual may request in writing that use or disclosure of health information be restricted. The Department will respond in writing, and may deny the request if: (3-17-22)

i. Disclosure is required; (3-17-22)

ii. Necessary for the safety of the individual or others; (3-17-22)

iii. Necessary for the provision of services, benefits or payment; or (3-17-22)

iv. The restriction is unreasonable. (3-17-22)

b. The uses and disclosures of confidential information are subject to a restriction after it is received and recorded by the Department. Department employees, contractors, and the individual may request the Department to terminate the restriction. The Department will notify the individual of its response to a request to terminate a restriction. (3-17-22)

07. Discovery. Records will be provided only in response to valid discovery in any federal or state criminal, civil or administrative proceeding, as required by the Public Records Act, Section 74-115(3), Idaho Code. (3-17-22)

076. -- 099. (RESERVED)

100. EXCEPTIONS TO REQUIREMENT FOR AUTHORIZATION.

~~Confidential information will be released without an authorization to individuals and entities in compliance with a court order, or if they are legally authorized to receive it. The following are exceptions to the requirement for an authorization:~~ ~~(3-17-22)~~

~~**01. Advocates and Guardians**. Federally recognized protection and advocacy agencies or duly appointed guardians ad litem have access to an individual's file as necessary to perform their legal functions. Guardians ad litem have access to records as provided in Section 16-1634, Idaho Code, except for:~~ ~~(3-17-22)~~

~~**a.** Drug abuse and sickle cell anemia records maintained by the Veteran's Administration (VA), as required by 38 USC Section 7332;~~ ~~(3-17-22)~~

~~**b.** Claims under laws administered by the VA as required by 38 USC Section 3301; and~~ ~~(3-17-22)~~

~~**c.** Drug abuse prevention programs that receive federal assistance, as required by 42 USC Section 290ee - 3.~~ ~~(3-17-22)~~

~~**02. Licensure**. In compliance with Section 74-106(9), Idaho Code, records will be released if they are part of an inquiry into an individual's or organization's fitness to be granted or retain a license, certificate, permit, privilege, commission or position. These records will otherwise be provided in redacted form as required by law or rule.~~ ~~(3-17-22)~~

~~**03. Fugitives and Missing Persons**.~~ ~~(3-17-22)~~

~~**a.** A state or local law enforcement officer may receive the current address of any cash assistance recipient who is a fugitive felon, in compliance with Section 56-221, Idaho Code.~~ ~~(3-17-22)~~

~~**b.** The following health information may be disclosed to a law enforcement officer for the purpose of identifying or locating a suspect, fugitive, material witness or missing person:~~ ~~(3-17-22)~~

~~i. Name and address;~~ ~~(3-17-22)~~

~~ii. Date and place of birth;~~ ~~(3-17-22)~~

~~iii. Social security number;~~ ~~(3-17-22)~~

~~iv. Blood type and rh factor;~~ ~~(3-17-22)~~

~~v. Type of injury;~~ ~~(3-17-22)~~

~~vi. Date and time of treatment or death, if applicable; and~~ ~~(3-17-22)~~

~~vii. Distinguishing physical characteristics.~~ ~~(3-17-22)~~

~~**c.** DNA, dental records, or typing, samples or analysis of body fluids or tissue must not be disclosed.~~ ~~(3-17-22)~~

~~**04. Duty to Warn or Report**. Confidential information may be released without an authorization if necessary under a legal duty to warn or to report.~~ ~~(3-17-22)~~

~~**05. Department Business, Monitoring and Legal Functions**. Department employees and contractors may use and disclose records as necessary to perform normal business functions, including health treatment, audit and quality improvement, investigation of fraud and abuse, establishment of overpayments and recoupment, public health, or other functions authorized by law. Information will be made available to state and federal auditors and compliance monitors. Confidential information will be provided to counsel as needed to evaluate, prepare for and represent the Department in legal actions.~~ ~~(3-17-22)~~

~~**06. Emergencies**. Confidential information may be disclosed to qualified medical personnel to the~~

extent necessary to respond to a medical emergency that requires immediate attention. (3-17-22)

07. Multidisciplinary Staffing. Confidential information may be disclosed to employees of the Department, law enforcement, and other appropriate individuals to participate in a multidisciplinary team evaluation of child protection cases under Section 16-1617, Idaho Code, or interdisciplinary Department staffing of services for an individual. All individuals who participate in such staffing must not redisclose the information and must comply with any other pertinent statute, rule or regulation. (3-17-22)

08. Collaborative Staffing. Confidential information may be disclosed in staffing by the Department and other individuals or entities if all participants are involved with the same or similar populations and have an equal obligation or promise to maintain confidentiality. Disclosure of information in inter-agency staffing must be necessary to coordinate benefits or services, or to improve administration and management of the services. Confidential information may be disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the staffing. All individuals who participate in such staffing must not redisclose the information except in compliance with any other pertinent statute, rule or regulation. (3-17-22)

09. Elected State Official. As provided by Section 16-1629(6), Idaho Code, any duly elected state official carrying out their official functions may have access to child protection records of the Department, and must not redisclose the information. (3-17-22)

10. Child Protection Agency. A legally mandated child protection agency may provide information necessary to investigate a report of known or suspected child abuse or neglect, or to treat a child and family who are the subjects of the record. (3-17-22)

11. Legally Authorized Agency. An agency will be provided appropriate information if the agency is legally responsible for or authorized to care for, treat or supervise a child who is the subject of the record. (3-17-22)

12. Informal Representatives. Informal representatives may be permitted to receive and deliver information on behalf of an individual, and may be given health information if the informal representative is directly involved with the individual's care. Confidential information may be withheld in whole or part if professional staff determines that disclosure is not in the best interest of the individual, based on the circumstances and their professional judgment. The Department will not disclose information that is prohibited from being disclosed by these rules or any other legal requirement. (3-17-22)

13. Law Enforcement. Any federal, state, or local law enforcement agency, or any agent of such agency, may be permitted access to information as needed in order to carry out its responsibilities under law to protect children from abuse, neglect, or abandonment. (3-17-22)

101. ABUSE, NEGLECT, OR DOMESTIC VIOLENCE.
Health information may be disclosed to a law enforcement officer if the victim of abuse, neglect, or domestic violence agrees to the disclosure. (3-17-22)

01. Incapacity of Victim. If the victim is unable to agree because of incapacity, health information will be disclosed if the officer states: (3-17-22)

a. That the information is not intended to be used against the victim; and (3-17-22)

b. That immediate enforcement activity would be materially and adversely affected by waiting for the victim's agreement. (3-17-22)

02. Judgment of Professional Staff. The victim must be promptly informed that a report to law enforcement has been or will be made unless in the judgment of professional staff: (3-17-22)

a. Informing the victim would place them at risk of serious harm; or (3-17-22)

b. The probable perpetrator of the abuse, neglect or domestic violence would be the recipient of the report, and disclosure would not be in the victim's best interest. (3-17-22)

102. VICTIM OF OTHER CRIME.
Health information may be disclosed in response to a law enforcement official's request about a victim or suspected victim of a crime other than those listed in Section 101 of these rules, if the individual agrees to the disclosure. (3-17-22)

01. Incapacity of Victim or Emergency Circumstance. If the individual is unable to agree because of incapacity or emergency circumstance, health information will be disclosed if the official states that the information is needed to determine whether a violation of law has occurred, and that it is not intended to be used against the individual. (3-17-22)

02. Best Interest of the Individual. The officer must also represent that immediate enforcement activity would be materially and adversely affected by waiting for the individual's agreement. Professional staff must agree that disclosure is in the best interest of the individual. (3-17-22)

103. SERIOUS THREAT TO HEALTH OR SAFETY.
Subject to the restrictions in this rule, health information may be used or disclosed if necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. Disclosure must be based on actual knowledge or credible information from a person with apparent knowledge or authority. Disclosure will be made only to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. (3-17-22)

01. Apprehension by Law Enforcement. Health information may be disclosed as necessary to law enforcement to identify or apprehend an individual. Disclosure is limited to an admission that an individual participated in a violent crime if it is reasonable to believe that serious physical harm has been caused to the victim. (3-17-22)

02. Escape From Law Enforcement. Health information may be disclosed as necessary for law enforcement to identify or apprehend an individual where it appears from all the circumstances that the individual has escaped from a correctional institution or lawful custody. (3-17-22)

03. Prohibition on Disclosure. Disclosure of an admission of participation in a violent crime is prohibited if the information is learned in the course of treatment to affect the individual's tendency to commit the criminal conduct, or through a request by the individual to initiate such treatment. (3-17-22)

104. REPORTING OF CRIME ON PREMISES.
Health information may be disclosed to a law enforcement official if the information constitutes evidence of criminal conduct that occurred on the Department's premises. (3-17-22)

105. REPORTING CRIME IN EMERGENCIES.
If a Department employee is providing emergency health care off the Department's premises, health information may be disclosed if necessary to alert law enforcement to a crime; the location of the crime or victim; and the identity, description and location of the perpetrator. If the crime involves abuse, neglect or domestic violence, the requirements of Section 101 of this chapter apply. (3-17-22)

106. – 124. (RESERVED)

125. ACCESS TO AN INDIVIDUAL'S OWN RECORD.
An individual who is at least fourteen (14) years old, or a legal representative, may review and obtain a copy of Department records that pertain to the individual, subject to the exceptions listed in Subsections 125.01 through 125.04 of these rules. Requests must be in writing, identifying the individual whose record is sought, and the record or information requested. The principles of disclosing only minimally necessary information on a need-to-know basis do not apply to a request for an individual's own records. The following information must not be disclosed:(3-17-22)

01. Children's Mental Health. Records of a child's mental health services must not be disclosed to the child when a physician or other mental health professional has noted that disclosure would be damaging to the child, unless access is ordered by a court according to Section 16-2428, Idaho Code. (3-17-22)

02. Legal Action. No disclosure will be made to an individual of information compiled in an ongoing investigation, that is exempt from disclosure, or that relates to adoption. Information compiled in reasonable anticipation of litigation that is not otherwise discoverable must not be disclosed. Information compiled for use in a civil, criminal, or administrative proceeding to which the individual is a party must not be disclosed except in compliance with valid discovery. (3-17-22)

03. Clinical Laboratories. There will be no disclosure of information maintained by a clinical laboratory except as authorized by the provider who ordered the test or study, in compliance with 42 USC 263a. (3-17-22)

04. Confidential Information. Health and other confidential information will not be disclosed to the individual if a licensed professional in an appropriate discipline determines that disclosure is likely to endanger the life or physical safety of the individual or another person. Disclosure to a legal representative will be denied if there is a professional determination that access by the representative is likely to cause substantial harm to the subject of the record or another person. (3-17-22)

126. – 149. (RESERVED)

150. AMENDMENT OF RECORD.
Unless otherwise provided by law, individuals may request in writing to amend the content of a record created by the Department. The Department will respond in writing within ten (10) days, granting or denying the amendment. A record created by a third party will not be amended by the Department. (3-17-22)

01. Amendment of Health Information. Once an amendment regarding health information is approved and recorded, the Department will provide the amended health information when the record is disclosed in the future. If an amendment of health information is denied, the individual may provide a written response, which the Department may rebut in writing to the individual. Upon request, documentation of all the records involved in the denial will be provided whenever that information is disclosed in the future. (3-17-22)

02. Updating Identifying Information. Name and address changes, and similar updates of information in Department files will be made without using the amendment process. (3-17-22)

151. – 174. (RESERVED)

175. REPORT OF DISCLOSURES OF HEALTH INFORMATION.

01. Documented Disclosures. The following disclosures of identifying health information for a purpose other than providing health treatment, payment or operations will be documented: (3-17-22)

a. Required by law; (3-17-22)

b. Public health activities; (3-17-22)

c. Related to victims of abuse, neglect or domestic violence; (3-17-22)

d. Health care oversight; (3-17-22)

e. Judicial and administrative proceedings; (3-17-22)

f. Correctional institutions or custodial law enforcement situations; (3-17-22)

g. Coroners, medical examiners, and funeral directors; (3-17-22)

h. Organ or tissue donations; (3-17-22)

i. Research; (3-17-22)

j. To avert a serious threat of health and safety; and (3-17-22)

k. Specialized government functions such as national security or intelligence. (3-17-22)

02. Documentation of Disclosure. Documentation will identify when the disclosure occurred, to whom, what information was disclosed and for what purpose. (3-17-22)

03. Maintenance of Documentation. The Department maintains documentation of these disclosures of health information for six (6) years. (3-17-22)

04. Request for Report of Disclosures. An individual or legal representative may receive one (1) free report of disclosures per calendar year for six (6) years beginning April 14, 2003. Additional requests for a report of disclosures are processed as public record requests, and may be subject to fees. (3-17-22)

05. Pending Investigation. The Department must suspend reporting of a disclosure of health information at the request of any federal, state or local entity that is conducting an investigation related to the oversight of health care, illegal discrimination, licensing, certification or accreditation. If the request is verbal, the suspension will terminate after thirty (30) days unless the request is renewed in writing. (3-17-22)

176. – 189. (RESERVED)

190. RECORDS OF DECEDENTS.
Records of decedents are confidential for as long as the Department maintains the records, except as needed by: (3-17-22)

01. Law Enforcement. If there is suspicion that the death was the result of criminal conduct. (3-17-22)

02. Coroners and Medical Examiners. Information may be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. (3-17-22)

03. Funeral Directors. Confidential information may be given to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary to carry out their duties, confidential information may be disclosed to funeral directors prior to and in reasonable anticipation of the individual's death. (3-17-22)

04. Personal Representatives. While records are maintained, the same confidentiality requirements apply to the personal representative of the estate or other legal representative of the deceased individual. Information may be disclosed to such representatives only to the extent necessary to perform their legal function, (3-17-22)

05. Family Members and Others. The Department may disclose health information to a family member, other relative, a close personal friend of the deceased individual, or any other person identified by the deceased individual. Information provided must be directly related to such person's involvement with the individual's care or payment for health care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the Department. (3-17-22)

191. DATA FOR RESEARCH OR OTHER PURPOSES.
Records that contain non-identifying information may be disclosed for Department-approved research or other purposes without a written authorization. (3-17-22)

192. – 199. (RESERVED)

SPECIFIC CONSENT AND DISCLOSURE REQUIREMENTS (Sections 200-283)

200. ABORTION FOR MINORS.

~~Consent for an abortion for a minor is governed by Section 18-609A, Idaho Code.~~ ~~(3-17-22)~~

~~201. ABUSE, NEGLECT OR DOMESTIC VIOLENCE.~~
~~Abuse, abandonment or neglect of a minor is required to be reported in compliance with Section 16-1605, Idaho Code. Abuse, neglect or exploitation of adults is governed by Section 39-5303, Idaho Code. An exception to the physician/patient privilege for domestic violence is contained in Section 9-203, Idaho Code.~~ ~~(3-17-22)~~

~~202. ADOPTION.~~
~~Disclosure of adoption records is governed by the provisions of Sections 74-105(6), 16-1501, 39-258, 39-259A, and 39-7501 through 39-7905, Idaho Code. Consent to adoption by children who are more than twelve (12) years old, by parents and by others, is governed by Section 16-1504, Idaho Code.~~ ~~(3-17-22)~~

~~203. -- 209. (RESERVED)~~

~~210. CHILD PROTECTION.~~
~~It shall be the policy of the Idaho Department of Health and Welfare to provide information to the maximum extent possible to carry out the department's responsibility under law to protect children from abuse and neglect and to facilitate child and family services. The Department, upon request will disclose information from child protection records in its possession pursuant to Section 74-105(7), Idaho Code. Disclosure of Department records under the Child Protective Act is governed by Section 16-1629(6), Idaho Code, and Idaho Court Administrative Rule 32. Court records of Child Protective Act proceedings are governed by Section 16-1626, Idaho Code. Pertinent federal laws and regulations include 42 USC 5106a.~~ ~~(7-1-25)~~

~~01. Child Fatalities~~. ~~In accordance with 42 USC 5106a(b)(2)(B)(x), the Department will disclose non-identifying summary information to the Statewide Child Fatality Review Team, established by the Governor's Task Force on Children at Risk, regarding child fatalities that were determined to be the result of abuse, neglect, or abandonment.~~ ~~(3-17-22)~~

~~02. Public Disclosure~~. ~~The Department has the discretion to disclose child-specific information under this rule when the disclosure is not in conflict with the child's best interests and one (1) or more of the following applies:~~ ~~(3-17-22)~~

~~a.~~ ~~Identifying information related to child-specific abuse, neglect, or abandonment has been previously published or broadcast through the media;~~ ~~(3-17-22)~~

~~b.~~ ~~All or part of the child-specific information has been publicly disclosed in a judicial proceeding; or~~ ~~(3-17-22)~~

~~c.~~ ~~The disclosure of information clarifies actions taken by the Department on a specific case.~~ ~~(3-17-22)~~

~~211. CHILDREN'S MENTAL HEALTH.~~
~~Consent to voluntary treatment for a minor with serious emotional disturbance, emergency and involuntary treatment are governed by the Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code. Section 16-2428, Idaho Code, describes requirements for confidentiality.~~ ~~(3-17-22)~~

~~212. -- 219. (RESERVED)~~

~~220. HARD TO PLACE CHILDREN.~~
~~The Department disseminates information to prospective adoptive families and families who wish to be appointed legal guardians of a child in the state's custody, as to the availability of hard-to-place children, adoption and guardianship procedures, and the existence of financial aid to adoptive families and guardians of hard-to-place children, in compliance with Section 56-804, Idaho Code.~~ ~~(3-17-22)~~

~~221. HOSPITAL RECORDS.~~
~~Records of hospitalization in a state facility are governed by Sections 39-1392b, 39-1392e and 39-1394, Idaho Code.~~ ~~(3-17-22)~~

222. HUMAN RESOURCES.
Disclosure of employee information is governed by Section 74-106(1), Idaho Code. (3-17-22)

223. INFANT/TODDLER PROGRAM.
Consent to early intervention services and confidentiality of records that relate to the Infant/Toddler program are governed by the Individuals with Disabilities Education Act (IDEA), 20 USC 1414(a)(1)(C) and (c)(3), and 20 USC 1415(b)(3); the Family Educational Rights and Privacy Act (FERPA), 20 USC 1232g; and 34 CFR 303.400, 34 CFR 303.500 and 34 CFR part 99. (3-17-22)

224. – 229. (RESERVED)

230. MEDICAL CARE.
Consent to apply for services or treatment is governed by Title 39, Chapter 45, Idaho Code, for hospital, medical, dental or surgical care, treatment or procedure. (3-17-22)

231. – 239. (RESERVED)

240. MENTAL ILLNESS.
Records of assessment, treatment, and commitment or hospitalization of individuals with mental illness are governed by Sections 66-318, 66-348, 66-355, 66-329(9), and 66-337, Idaho Code. (3-17-22)

241. MINOR'S CONSENT REGARDING INFECTIOUS, CONTAGIOUS OR COMMUNICABLE DISEASE.
Section 39-3801, Idaho Code, governs consent to treatment for infectious, contagious or communicable disease by a minor who is at least fourteen (14) years of age. (3-17-22)

242. SPECIFIC REQUIREMENTS – PROTECTION AND ADVOCACY AGENCIES.
A protection and advocacy system for individuals who have a developmental disability is created by 42 USC 15042 et seq.; for individuals with mental illness, by 42 USC 10801. Advocacy for adult protection is governed by Sections 39-5307 and 39-5308, Idaho Code. (3-17-22)

243. – 249. (RESERVED)

250. SUBSTANCE ABUSE.
Consent to treatment and confidentiality of alcohol and drug abuse patient records are governed by 42 CFR 2.12 through 2.67, and Sections 37-2743, 37-3102, 39-307, and 39-308, Idaho Code. (3-17-22)

01. Drug Abuse. A medical practitioner will not disclose identifying information, treatment or request for treatment, to any law enforcement officer or agency or in any proceeding, in compliance with Sections 37-2743 and 37-3102, Idaho Code. (3-17-22)

02. Age Sixteen and Over. Information regarding substance abuse treatment of an individual who is at least age sixteen (16) years old will not be disclosed to a parent or guardian unless authorized by the individual, in compliance with Section 37-3102, Idaho Code, and 42 CFR 2.14. Individuals who are at least sixteen (16) years old may consent to substance abuse treatment. (3-17-22)

251. – 259. (RESERVED)

260. TERMINATION OF PARENTAL RIGHTS.
Disclosure of information regarding the termination of parental rights is governed by Section 16-2013, Idaho Code. (3-17-22)

261. – 269. (RESERVED)

270. VENEREAL DISEASES.
Disclosures of health information pertaining to the control of venereal diseases, including Human Immunodeficiency

~~Virus (HIV), is governed by Title 39, Chapter 6, Idaho Code.~~ ~~(3-17-22)~~

~~271. —~~ 279. (RESERVED)

280. VITAL STATISTICS -- VERIFICATION OF DATA.

01. **Verifications**. The Registrar will confirm or deny the presence and accuracy of data already known to a governmental agency that requests information from a vital record. Such verifications may be conducted by telephone for Idaho state agencies. Other requests for verification require a signed application on forms provided or approved by the Registrar, and a copy of the front and back of signed photo identification or such other information as the Registrar requests. Verifications may also be conducted via Department automated systems approved by the Registrar. (3-17-22)

02. **Administrative Fact of Death Verifications**. Upon agreement in writing to such conditions as the Registrar may impose, the Registrar may compare Idaho state agency administrative data to Idaho death data and return an indication of death, also known as fact of death verification, for administrative purposes only. (3-17-22)

03. **Verifications to Protect a Person's Property Right**. The State Registrar may approve electronic fact of death verification by entities seeking to determine or protect a person's property right. (3-17-22)

281. VITAL STATISTICS: DISCLOSURE FOR RESEARCH, PUBLIC HEALTH OR STATISTICAL PURPOSES.
Upon agreement in writing to such conditions as the Registrar may impose, the Registrar may permit the use of data from vital statistics records for research, public health or statistical purposes. The Registrar may deny a request for access to identifying information if the Registrar determines that the benefits would be outweighed by the possible adverse consequences to those individuals whose records would be used. (3-17-22)

~~282. VITAL STATISTICS: REGISTRY OF PUTATIVE FATHERS.~~
~~Except by Idaho court order or in accordance with the provisions of Section 16-1513, Idaho Code, information acquired by the confidential registry of putative fathers will not be disclosed.~~ ~~(3-17-22)~~

282. (RESERVED)

283. VITAL STATISTICS: PROCEDURES FOR REQUESTING INFORMATION.
Individuals who request access to, information from, or copies of vital records must present a signed application on forms provided or approved by the Registrar, and a copy of the front and back of signed photo identification or such other information as the Registrar requests. ~~Minors who are less than fourteen (14) years old may receive certified copies of vital records that pertain to them if they present the required information.~~ ~~(3-17-22)~~( )

01. **Expedited Copy**. An expedited certified copy of a vital record may be issued using Department automated systems. (3-17-22)

02. **Certified Copy**. When a certified copy is issued, it is certified as a true copy or abstract of the original vital record by the ~~officer who has custody of the record~~ Registrar. The certified copy will include the date issued, the Registrar's signature or an authorized facsimile thereof, and the seal of the issuing office and excluding information contained in the statistical section of any record. Full or short form certified copies of vital records may be ~~made by mechanical, electronic or other reproduction processes~~ issued. ~~(3-17-22)~~( )

~~284. WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM.~~
~~WIC information may be used and disclosed only for the purpose of establishing the eligibility of WIC applicants and participants for health and welfare programs.~~ ~~(3-17-22)~~

28~~5~~4. -- 999. (RESERVED)

IDAPA 34 – SECRETARY OF STATE

34.03.01 – RULES IMPLEMENTING THE SUNSHINE LAW

DOCKET NO. 34-0301-2501

NOTICE OF RULEMAKING – PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-223(2)(f) Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than June 18, 2025.

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

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking: this rulemaking proposes to remove rules related to lobbyists following the passage of House Bill 398. The underlying code requiring annual reporting, Section 67-6619, was repealed. The registration form and fee, as well as the requirements for monthly reporting, were codified in the new Chapter 7, Title 74, Idaho Code.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because House Bill 398 from the 2025 Legislative Session repealed the annual reporting requirement and codified in a new Chapter 7, Title 74, Idaho Code, the registration form and fee, as well as the monthly reporting requirements.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Robert McQuade at (208) 334-2300. Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before June 25, 2025.

DATED this 2nd day of May, 2025.

Robert H. McQuade, Jr.
Assistant Chief Deputy
Idaho Secretary of State's Office
700 W. Jefferson St., Room E205 Boise, ID 83702
P.O. Box 83720
Boise, ID 83720-0080
(208) 334-2852

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 34-0301-2501
(Only Those Sections With Amendments Are Shown.)

34.03.01 – RULES IMPLEMENTING THE SUNSHINE LAW

000. LEGAL AUTHORITY.
This chapter is promulgated pursuant to Chapter 66, Title 67, Idaho Code, specifically Sections 67-6603, 67-6607, 67-6608, 67-6610, 67-6611, 67-6612, 67-6614A, ~~67-6619,~~ 67-6623, Idaho Code. ~~(3-31-22)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

011. FORMS.

~~01.~~ ~~Form for Lobbyist Registration~~. ~~Pursuant to the authority of Section 23 of the Sunshine Law the official form for lobbyist registration as required by Section 17 is hereby adopted for use in reporting to the Secretary of State. This form shall be designated as "L-1" and shall be available online. The "L-1" form shall be accompanied by payment of a registration fee of ten dollars ($10).~~ ~~(3-31-22)~~

~~02.~~ ~~Annual Report Form~~. ~~The official form for the lobbyist annual report as required by Section 67-6619, Idaho Code is hereby adopted for use in reporting to the Secretary of State. This form shall be designated as "L-2" and shall be available online.~~ ~~(3-31-22)~~

~~a.~~ ~~Expenditures to be reported are those made or incurred by such lobbyist or on behalf of such lobbyist by the lobbyist's employer either directly or indirectly for lobbying purposes. The total expenditures shall be cumulative for the calendar year covered by the report. Expenditure categories shall include entertainment, food and refreshment, advertising, living accommodations, travel, telephone, and other expenses or services.~~ ~~(3-31-22)~~

~~b.~~ ~~The annual report shall include the name and address of the lobbyist and the name and address of the lobbyist's employer(s), and the subject matter or proposed legislation and the number of each senate or house bill, resolution, or other legislative activity which the lobbyist has been engaged in supporting or opposing during the reporting period; provided that in the case of appropriation bills the lobbyist shall enumerate the specific section or sections which he supported or opposed.~~ ~~(3-31-22)~~

~~c.~~ ~~The annual report shall be certified as a true, complete, and correct statement by the lobbyist and the lobbyist's employer(s).~~ ~~(3-31-22)~~

~~03.~~ ~~Monthly Report Form~~. ~~The official form for the lobbyist monthly report as required by Section 67-6619, Idaho Code is hereby adopted for use in reporting to the Secretary of State. This form shall be designated as "L-3" and shall be available online.~~ ~~(3-31-22)~~

~~a.~~ ~~Expenditures to be reported are those made or incurred by such lobbyist or on behalf of such lobbyist by the lobbyist's employer either directly or indirectly for lobbying purposes. The expenditure totals in such reports shall not be cumulative throughout the year but rather shall reflect the total expenditures during the calendar month covered by the report. Expenditure categories shall include entertainment, food and refreshment; advertising; living accommodations; travel; telephone; and other expenses or services.~~ ~~(3-31-22)~~

~~b.~~ ~~The monthly periodic report shall include the name and address of the lobbyist and the name and address of the lobbyist's employer; and the subject matter of proposed legislation and the number of each senate or house bill, resolution, or other legislative activity which the lobbyist has been engaged in supporting or opposing during the reporting period; provided that in the case of appropriation bills the lobbyist shall enumerate the specific section or sections which he supported or opposed.~~ ~~(3-31-22)~~

~~e. The monthly report shall be certified as a true, complete, and correct statement by the lobbyist.~~ ~~(3-31-22)~~

041. Form for the Appointment and Certification of Political Treasurer. The official form for the appointment and certification of a political treasurer as required by Section 67-6603, Idaho Code is hereby adopted for use in reporting to the Secretary of State. This form shall be numbered "C-1" designated as "Appointment and Certification of Political Treasurer for Candidates and Committees" and shall be available online. (3-31-22)

052. Forms for the Disclosure of Campaign Finances by Candidates and Political Committees. The official forms for the statement required by Sections 67-6607, 67-6608, and 67-6612, Idaho Code are hereby adopted for use in reporting to the Secretary of State. The form numbered "C-2" shall be designated "Campaign Financial Disclosure Report" and shall be available online. The form numbers "C-2A" shall be designated "Contributions Pledged But Not Yet Received" and shall be available online. The form numbered "C-2B" shall be designated "Expenditures Incurred (Debts and Obligations) and Payments Made on Debt" and shall be available online. (3-31-22)

063. Form for Report of Alleged Violation of Sunshine Law. Pursuant to the authority of Section 67-6623(f), Idaho Code of the Sunshine Law the official form to be used in filing a complaint that a person has violated the Sunshine Law is hereby adopted for use in reporting to the Secretary of State. This form shall be designated as "L-5" and shall be available online. Any person may file a complaint against anyone covered by the Sunshine Law. Such complainant must submit form "L-5" to properly file his complaint. No other method of filing a complaint will be recognized. (3-31-22)

IDAPA 45 – IDAHO HUMAN RIGHTS COMMISSION

45.01.01 – RULES OF THE IDAHO HUMAN RIGHTS COMMISSION

DOCKET NO. 45-0101-2501

NOTICE OF INTENT TO PROMULGATE RULES – ZERO-BASED REGULATION (ZBR) NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Section 67-5906 et seq., Idaho Code, and Section 44-1703 et seq., Idaho Code.

MEETING SCHEDULE: Negotiated rulemaking meetings will be held as follows:

Thursday, June 5, 2025 **3:30 p.m. MT**
In Person: **317 W Main St, Boise ID 83702** **Virtual:** **Join by meeting link**

Thursday, July 3, 2025 **3:30 p.m. MT**
In Person: **317 W Main St, Boise ID 83702** **Virtual:** **Join by meeting link**

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

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following: Submit written comments to the administrator in writing for the record or provide a written request for oral testimony at a hearing scheduled as described above. Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved: These rules are being presented for authorization as part of the Idaho Human Rights Commission's plan to review each rule every 5 years. There are several rulemaking changes planned by the Commission at this time, including removal of section 004 entitled "Declaratory Rulings," and several other minor changes consistent with the Governor's Zero-Based Regulation Executive Order. It is anticipated that rulemaking stakeholders will propose and advocate for rulemaking changes as part of the negotiated rulemaking process. The Commission intends to carefully consider all

changes presented by the public and may propose certain changes so long as they are consistent with the rules' statutory authority and the Governor's Executive Order. The Commission will review the documents that are currently incorporated by reference in this rule and update that list as applicable.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text, contact Benjamin Earwicker at (208) 696-2448. Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho Human Rights Commission website at the following web address: https://humanrights.idaho.gov/.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 31, 2025.

DATED this 2nd day of May, 2025.

Benjamin Earwicker
Administrator
Idaho Human Rights Commission
317 W. Main St.
Boise, ID 83735
Phone: (208) 696-2448
Email: benjamin.earwicker@labor.idaho.gov

IDAPA 55 – DIVISION OF CAREER TECHNICAL EDUCATION

55.01.03 – RULES OF CAREER TECHNICAL CENTERS

DOCKET NO. 55-0103-2501

NOTICE OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to sections 33-1002G, in Idaho Code.

MEETING SCHEDULE: A negotiated rulemaking meeting will be held as follows:

Thursday, June 12, 2025
3:00 p.m. MT

In Person:
650 W State St. Boise, ID 83702
3rd Floor, Clearwater Conference Room

Join by Zoom Link:
https://us02web.zoom.us/j/82840097182
Meeting ID: 828 4009 7182

The meeting site(s) will be accessible to persons with disabilities, if needed. Requests for accommodation must be made at least one (1) day prior to the meeting to the agency address below.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do the following:

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusion reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

The methodology for distributing added cost funds to Career Technical Centers (CTCs) is in part based on the number of concentrator students, the current definition in rule identifies those students as students in a capstone course, the current definition in Perkins V (Public Law 115-224), is those students who take more than two CTE courses in a program. The definition needs to be updated to match the Perkins V definition. Additionally, the participation data definition needs to be edited so it is clear that only concentrator students who are in a capstone course will be counted. Lastly, the methodology used in subsection 105 will be reviewed so to make sure definitions maintain the current group of students being counted. The change will maintain the current methodology for distributing these funds and have no direct impact on funding.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text contact Nicholas Wagner at rules@edu.idaho.gov or (208)-488-7586.

Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Idaho State Board of Education website at the following web address: https://boardofed.idaho.gov/board-policies-rules/board-rules/education-rules/.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 2, 2025.

DATED this 3rd day of May, 2025.

Nicholas Wagner
Administrative Rules Coordinator, Idaho State Board of Education
650 W State St., PO Box 83720, Boise, ID 83720-0037
Phone: (208)488-7586; Fax: (208)334-2632

IDAPA 62 – OFFICE OF ADMINISTRATIVE HEARINGS

62.01.01 – IDAHO RULES OF ADMINISTRATIVE PROCEDURE

DOCKET NO. 62-0101-2501

NOTICE OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency intends to promulgate rules and desires public comment and input prior to initiating formal rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Sections 67-5206(3) and 67-5280(2)(c), Idaho Code.

MEETING SCHEDULE: Negotiated rulemaking meetings are planned to be held as follows:

Friday, June 27, 2025
1:00 p.m. -2:00 p.m. MT

In Person:
Idaho State University, Pond Student Union Building, Sargent Boardroom
1080 S. 5th Ave., Pocatello, ID 83209

Virtual:
https://us02web.zoom.us/j/82374104212?pwd=hbOS43KEDFrYjuFfTt4dZuHWaKPvW3.1
Meeting ID: 823 7410 4212
Passcode: 259056

Monday, July 7, 2025
11:00 a.m. -12:00 p.m. MT

In Person:
Twin Falls Library, Meeting Room
201 4th Ave E., Twin Falls, ID 83301

Virtual:
https://us02web.zoom.us/j/84721203270?pwd=0l9q0ldzJpLDf92kWAD62rLEMLxXPE.1
Meeting ID: 847 2120 3270
Passcode: 839768

Tuesday, July 8, 2025
11:00 a.m. -12:00 p.m. PT

In Person:
North Idaho College, Crescent Bay Conference Room, Edminster Student Union Building
495 N. College Dr., Coeur d'Alene, ID 83814

Virtual:
https://us02web.zoom.us/j/83970284340?pwd=dbnXzEXcvbk8ma57zKCZfBNprhE7a7.1
Meeting ID: 839 7028 4340
Passcode: 154077

Wednesday, July 9, 2025
10:00 a.m. -12:00 p.m. MT

In Person:
Joe R. Williams Building, 1st Floor, East Conference Room
700 W. State Street, Boise, ID 83702

Virtual:
https://us02web.zoom.us/j/84001531711?pwd=VF0e1paQpdzpZjHKdRw7yTB6onJaI4.1
Meeting ID: 840 0153 1711
Passcode: 387110

Monday, July 21, 2025
1:00 p.m. -2:00 p.m. PT

In Person:
University of Idaho Law School, Clinic Conference Room #9
711 S. Rayburn St., Moscow, ID 83844

Virtual:
https://us02web.zoom.us/j/81405079841?pwd=bB2NAgmbd7sHn4gKlSlhlMgAUm5Enq.1
Meeting ID: 814 0507 9841
Passcode: 976743

The meeting site(s) will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below. Any changes to the above meeting schedule will be posted to Townhall Idaho, https://townhall.idaho.gov/. Any additional meeting dates will be posted at Townhall Idaho, as well as https://oah.idaho.gov/rulemaking-docket-no-62-0101-2501/.

METHOD OF PARTICIPATION: Persons wishing to participate in the negotiated rulemaking must do any of the following:

- Attend the negotiated rulemaking meeting, in-person or remotely, and participate in the negotiation process;
- Provide oral or written recommendations, or both, at the negotiated rulemaking meeting; and/or
- Submit written recommendations and comments to the address below.

Upon conclusion of the negotiated rulemaking, any unresolved issues, all key issues considered, and conclusions reached during the negotiated rulemaking will be addressed in a written summary. The summary will be made available to interested persons who contact the agency or, if the agency chooses, the summary may be posted on the agency website.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a statement in nontechnical language of the substance and purpose of the intended negotiated rulemaking and the principal issues involved:

Provides updates/revisions/clean-ups to the Idaho Rules of Administrative Procedure (IDAPA 62.01.01), to include changes necessitated by passage of HB9a and HB36.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this negotiated rulemaking or to obtain a preliminary draft copy of the rule text (when available), contact Chief Administrative Hearing Officer Bryan Nickels at 208-605-4300 (include the appropriate name and phone number). Materials pertaining to the negotiated rulemaking, including any available preliminary rule drafts, can be found on the Office of Administrative Hearings' website at the following web address: oah.idaho.gov.

Anyone may submit written comments regarding this negotiated rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 31, 2025.

DATED this 1st day of May, 2025.

Bryan Nickels
Chief Administrative Hearing Officer
Office of Administrative Hearings
350 N. 9th St., Suite 300 (physical and mailing)
Boise, ID 83702
208-605-4300

Sections Affected Index

IDAPA 13 – IDAHO DEPARTMENT OF FISH AND GAME

13.01.04 – Rules Governing Licensing

Docket No. 13-0104-2501

508. – 5498. (Reserved) 32
549. 2026 NR Draw Hunts For Elk And Deer. 32
550. Nonresident Deer And Elk Tag Quotas. 33

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.10 – Idaho Reportable Diseases

Docket No. 16-0210-2501 (ZBR Chapter Rewrite)

000. Legal Authority. 37
001. Title And Scope. 37
002. Documents Incorporated By Reference. 37
003. Disclosure of Information. 38
0043. -- 009. (Reserved) 38
010. Definitions A Through K. 38
011. Definitions L Through Z. 40
012. -- 019. (Reserved) 42
020. Persons Required To Report Reportable Diseases, Conditions, And School Closures. 42
021. Access To Medical Records. 42
022. Penalty Provisions. 42
023. Delegation Of Powers And Duties. 42
0242. -- 029. (Reserved) 43
030. Where To Report Reportable Diseases And Conditions. 43
031. -- 039. (Reserved) 44
040. Report Contents And Method Of After-Hours Reporting. 44
041. -- 049. (Reserved) 44
050. Reportable Or Restrictable Diseases, Conditions And Reporting Requirements. 45
051. -- 059. (Reserved) 49
060. Testing For Certain Reportable Diseases When Informed Consent Is Not Possible. 50
06151. -- 064. (Reserved) 50
065. Investigation And Control Of Reportable Diseases. 50
066. -- 067. (Reserved) 52
068. Preventing Spread Of Health Hazards From Dead Human Bodies. 52
069. (Reserved) 52
070. Special Disease Investigations. 52
071. -- 079. (Reserved) 52
080. Daycare Facility - Reporting And Control Measures. 52
081. -- 084. (Reserved) 53
085. Food Service Facility - Reporting And Control Measures. 53
086. -- 089. (Reserved) 53
090. School - Reporting And Control Measures. 53
091. Handling of Report. 53
092. Restrictions. 54
093. Testing Without Informed Consent. 58
0914. -- 099. (Reserved) 58
100. Acquired Immune Deficiency Syndrome (AIDS). 58
1010. -- 109. (Reserved) 59
110. Amebiasis And Free-Living Amebae. 59
111. -- 11959. (Reserved) 59
120. Anthrax. 59

121. -- 124. (Reserved) 60
125. Arboviral Diseases. 60
126. -- 129. (Reserved) 60
130. Biotinidase Deficiency. 60
131. -- 139. (Reserved) 60
140. Botulism. 60
141. -- 149. (Reserved) 60
150. Brucellosis. 60
151. -- 159. (Reserved) 60
160. Campylobacteriosis. 60
161. -- 169. (Reserved) 61
170. Cancer. 61
171. -- 179. (Reserved) 62
180. Chancroid. 62
181. -- 189. (Reserved) 62
190. Chlamydia Trachomatis. 62
191. -- 199. (Reserved) 62
200. Cholera. 62
201. -- 209. (Reserved) 63
210. Congenital Hypothyroidism. 63
211. -- 219. (Reserved) 63
220. Cryptosporidiosis. 63
221. -- 229. (Reserved) 63
230. Diphtheria. 63
231. -- 234. (Reserved) 64
235. Echinococcosis. 64
236. -- 239. (Reserved) 64
240. Encephalitis, Viral Or Aseptic. 64
241. -- 249. (Reserved) 64
250. Escherichia coli O157:h7 And Other Shiga-Toxin Producing E. coli (STEC). 64
251. -- 259. (Reserved) 65
260. Extraordinary Occurrence Of Illness, Including Clusters. 65
261. -- 269. (Reserved) 65
270. Food Poisoning, Foodborne Illness, And Waterborne Illness. 65
271. -- 279. (Reserved) 66
280. Galactosemia. 66
281. -- 289. (Reserved) 66
290. Giardiasis. 66
291. -- 299. (Reserved) 66
300. Haemophilus Influenzae Invasive Disease. 66
301. -- 309. (Reserved) 67
310. Hantavirus Pulmonary Syndrome. 67
311. -- 319. (Reserved) 67
320. Hemolytic-Uremic Syndrome (HUS) 67
321. -- 329. (Reserved) 67
330. Hepatitis A. 67
331. -- 339. (Reserved) 68
340. Hepatitis B. 68
341. -- 349. (Reserved) 68
350. Hepatitis C. 68
351. -- 359. (Reserved) 69
360. Human Immunodeficiency Virus (HIV). 69

361. -- 369. (Reserved) ... 69
370. Human T-Lymphotropic Virus. ... 69
371. -- 379. (Reserved) ... 69
380. Lead Poisoning. ... 69
381. -- 389. (Reserved) ... 69
390. Legionellosis. ... 69
391. -- 399. (Reserved) ... 70
400. Leprosy (Hansen's Disease). ... 70
401. -- 409. (Reserved) ... 70
410. Leptospirosis. ... 70
411. -- 419. (Reserved) ... 70
420. Listeriosis. ... 70
421. -- 429. (Reserved) ... 70
430. Lyme Disease. ... 70
431. -- 439. (Reserved) ... 71
440. Malaria. ... 71
441. -- 449. (Reserved) ... 71
450. Maple Syrup Urine Disease. ... 71
451. -- 459. (Reserved) ... 71
460. Measles (Rubeola). ... 71
461. -- 469. (Reserved) ... 71
470. Meningitis, Viral Or Aseptic. ... 72
471. -- 474. (Reserved) ... 72
475. Methicillin-Resistant Staphylococcus Aureus (MRSA). ... 72
476. -- 479. (Reserved) ... 72
480. Mumps. ... 72
481. -- 489. (Reserved) ... 73
490. Myocarditis, Viral. ... 73
491. -- 499. (Reserved) ... 73
500. Neisseria Gonorrhoeae. ... 73
501. -- 509. (Reserved) ... 73
510. Neisseria Meningitidis Invasive Disease. ... 73
511. -- 519. (Reserved) ... 74
520. Norovirus. ... 74
521. (Reserved) ... 74
522. Novel Influenza A Virus. ... 74
523. -- 529. (Reserved) ... 74
530. Pertussis. ... 74
531. -- 539. (Reserved) ... 75
540. Phenylketonuria. ... 75
541. -- 549. (Reserved) ... 75
550. Plague. ... 75
551. -- 559. (Reserved) ... 76
560. Pneumococcal Invasive Disease In Children Less Than Eighteen Years Of Age. ... 76
561. -- 569. (Reserved) ... 76
570. Pneumocystis Pneumonia (PCP). ... 76
571. -- 579. (Reserved) ... 76
580. Poliomyelitis. ... 76
581. -- 589. (Reserved) ... 77
590. Psittacosis. ... 77
591. -- 599. (Reserved) ... 77
600. Q Fever. ... 77

601. -- 609. (Reserved) ... 77
610. Rabies - Human, Animal, And Post-Exposure Prophylaxis (rPEP). ... 77
611. -- 619. (Reserved) ... 79
620. Relapsing Fever, Tick-Borne And Louse-Borne. ... 79
621. -- 629. (Reserved) ... 79
630. Respiratory Syncytial Virus (RSV). ... 79
631. -- 639. (Reserved) ... 79
640. Reye Syndrome. ... 79
641. -- 649. (Reserved) ... 80
650. Rocky Mountain Spotted Fever. ... 80
651. -- 659. (Reserved) ... 80
660. Rubella - Including Congenital Rubella Syndrome. ... 80
661. -- 669. (Reserved) ... 80
670. Salmonellosis - Including Typhoid Fever. ... 80
671. -- 679. (Reserved) ... 82
680. Severe Acute Respiratory Syndrome (SARS). ... 82
681. -- 689. (Reserved) ... 82
690. Severe Reaction To Any Immunization. ... 82
691. -- 699. (Reserved) ... 82
700. Shigellosis. ... 82
701. -- 709. (Reserved) ... 83
710. Smallpox. ... 83
711. -- 719. (Reserved) ... 84
720. Streptococcus Pyogenes (Group A Strep) Infections. ... 84
721. -- 729. (Reserved) ... 84
730. Syphilis. ... 84
731. -- 739. (Reserved) ... 84
740. Tetanus. ... 84
741. -- 749. (Reserved) ... 85
750. Toxic Shock Syndrome. ... 85
751. -- 759. (Reserved) ... 85
760. Transmissible Spongiform Encephalopathies (TSE), Including Creutzfeldt-Jakob Disease (CJD) And Variant CJD (VCJD). ... 85
761. -- 769. (Reserved) ... 85
770. Trichinosis. ... 85
771. -- 779. (Reserved) ... 85
780. Tuberculosis. ... 85
781. -- 789. (Reserved) ... 86
790. Tularemia. ... 86
791. -- 809. (Reserved) ... 86
810. Yersiniosis, Other Than Plague. ... 86
811. -- 949. (Reserved) ... 87
950. Delegation Of Powers And Duties. ... 87
951. -- 999. (Reserved) ... 87

16.02.27 – Idaho Radiation Control Rules

Docket No. 16-0227-2501 (ZBR Chapter Rewrite)

000. Legal Authority. ... 90
001. Title And Scope. ... 90
002. -- 003. (Reserved) ... 90
004. Incorporation By Reference. ... 90
005. -- 049. (Reserved) ... 91
050. Licensing. ... 91

051. Machines Required To Be Licensed. 91
052. Fees. 91
053. Application For License. 92
054. -- 099. (Reserved) 95
100. General Provisions. 95
101. Scope. 95
102. Definitions. 95
103. Violations. 96
104. Impounding. 96
105. Communications. 96
106. -- 199. (Reserved) 96
200. Licensure Of Radiation Machine Facilities, (Services) - And Associated Healthcare Professionals. 96
201. Licensure of Radiation Machine Facilities. 96
202. Reciprocal Recognition Of Out-Of-State Radiation Machines. 96
203. -- 399. (Reserved) 96
400. Radiation Safety Requirements For Industrial Radiographic Operations. 96
401. Licensing And Registration Requirements For Industrial Radiography Operations. 96
402. Leak Testing And Replacement Of Sealed Sources. 96
403. Quarterly Inventory. 96
404. Labeling, Storage, And Transportation. 97
405. Conducting Industrial Radiographic Operations. 97
406. Records Of Leak Testing Of Sealed Sources And Devices Containing DU. 97
407. Records Of Quarterly Inventory. 97
408. Utilization Logs. 97
409. Location Of Documents And Records. 97
410. Notifications. 97
411. Application And Examinations. 97
412. Certification Identification (ID) Card. 97
413. Reciprocity. 97
414. Specific Requirements For Radiographic Personnel Performing Industrial Radiography. 97
415. -- 599. (Reserved) 97
600. Notices, Instructions And Reports To Workers; Inspections. 97
002. Definitions. 97
003. License Requirements And Application. 97
004. License Renewal And Fees. 98
005. X-Ray Shielding Plan Approval. 98
006. On-Site Inspection. 98
007. X-Ray Machine Quality Control and Quality Assurance. 98
008. X-Ray Machine Performance Standards. 99
009. X-Ray Facility And Operator Training Requirements. 99
010. License Modification, Suspension, or Revocation. 100
601011. -- 999. (Reserved) 100

16.03.21 – Developmental Disabilities Agencies (DDA)

Docket No. 16-0321-2501 (Chapter Rewrite)

000. Legal Authority. 102
001. Scope. 103
002. -- 008. (Reserved) 103
009. Criminal History And Background Check Requirements. 103
010. Definitions -- A Through Z. 103
011. -- 074. (Reserved) 105
075. DDA Services. 105

076. -- 099. (Reserved) 105
100. Types Of Certificates IssuedCertification Requirements for DDA, Residential Habilitation Agencies, and Adult Residential Care Facilities. 105
101. Application For Initial Certification. 105
1021. -- 10916. (Reserved) 108
110. Department's Written Decision Regarding Application For Certification. 108
111. Denial Of An Application. 109
112. -- 114. (Reserved) 109
115. Changes That Require Reporting. 109
116. Certificate Not Transferable. 110
117. Restriction On Certification. 110
118. Availability Of Certificate. 110
1197. Agencies Organizations Approved Through National Accreditation. 110
120. Renewal And Expiration Of The Certificate. 110
12118. -- 299. (Reserved) 110
300. General Staffing Requirements For Agencies. 110
301. Agency Organization Record Requirements. 111
302. General Training Requirements. 113
303. -- 399403. (Reserved) 114
400. Facility Standards For Agencies Providing Center-Based Services. 114
401. Setting Requirements. 115
402. Transportation Policy. 116
403. Health Policy. 116
404. Agency Organization Reporting Policy. 116
405. Medication Policy. 117
406. Grievance Policy. 118
4076. – 499. (Reserved) 118
500. Requirements For An Agency's Organization's Quality Assurance Program. 119
501. -- 504. (Reserved) 119
505. Participant Rights. 119
506. -- 509. (Reserved) 120
510. Policies And Procedures Regarding Development Of Restrictive InterventionsManaging Participant Behavior. 120
511. Standards For A DDA center and Adult Residential Care Facility. 121
512. Residential Habilitation Agencies Termination Procedures. 123
5113. -- 599. (Reserved) 123
600. Enforcement Process. 123
601. Revocation Of Certificate. 124
602. Notice Of Enforcement Remedy. 125
602. Injunction To Prevent Operation Without Certificate. 125
603. Waivers. 125
6034. -- 999. (Reserved) 125

16.03.22 – Residential Assisted Living Facilities

Docket No. 16-0322-2501 (ZBR Chapter Rewrite)

000. Legal Authority. 127
001. Title, Scope, And Responsibilities. 128
002. Written Interpretations. 128
003. Administrative Appeals And Contested Cases. 128
004. Incorporation By Reference. 128
0052. -- 008. (Reserved) 129
009. Criminal History And Background Check Requirements. 129
010. Definitions And Abbreviations A Through E. 130

011. Definitions And Abbreviations F Through N. 132
012. Definitions And Abbreviations O Through Z. 133
0131. -- 049. (Reserved) 136
050. Variances. 136
051. -- 099. (Reserved) 136
100. Licensing Requirements. 136
101. -- 104. (Reserved) 137
105. Change Of Ownership. 137
106. -- 109. (Reserved) 137
110. Facility License Application. 137
111. -- 114. (Reserved) 138
115. Expiration And Renewal Of License. 138
116. -- 125. (Reserved) 139
126. Effect Of Enforcement Action Against A License. 139
127. Frequency of Inspections. 139
1278. – 14950. (Reserved) 139
150. Policies And Procedures. 139
151. Activity Requirements. 139
152. Admission Requirements. 139
153. Financial Requirements. 140
154. Staff Training Resident Safety Requirements. 140
155. Emergency Preparedness Requirements. 142
156. Hourly Adult Care Requirements. 142
157. -- 160. (Reserved) 143
161. Smoking Requirements. 143
162. – 215. (Reserved) 143
216. Requirements For Resident Admission Agreements. 143
217. Requirements For Termination Of Admission Agreement. 146
218. -- 249. (Reserved) 147
250. Requirements For Building Construction And Physical Standards. 147
251. -- 254. (Reserved) 150
255. Requirements For Additional Physical Standards. 150
256. -- 259. (Reserved) 150
260. Requirements For Environmental Sanitation. 150
261. – 304. (Reserved) 152
305. Requirements For The Licensed Registered Nursing Assessment. 152
306. -- 309. (Reserved) 153
310. Requirements For Medications and Treatments. 153
311. -- 3189. (Reserved) 154
319. Comprehensive Assessment Requirements. 154
320. Negotiated Service Agreement (NSA) Requirements. 155
321. -- 329. (Reserved) 156
330. Requirements For Facility Records. 156
331. -- 334. (Reserved) 160
335. Requirements For Infection Control. 160
336. -- 399404. (Reserved) 161
400. Requirements For Fire And Life Safety Standards. 161
401. Fire And Life Safety Standards For New Buildings Housing Three Through Sixteen Residents. 161
402. Fire And Life Safety Standards For New Buildings Housing Seventeen Or More Residents And Multi-story Buildings. 161
403. Fire And Life Safety Standards For Existing Buildings Licensed For Three Through Sixteen Residents. 161

404. Fire And Life Safety Standards For Existing Buildings Licensed For Seventeen Or More Residents And Multi-story Buildings. 161
405. Additional Fire And Life Safety Standards For All Buildings And Facilities. 161
406. -- 409. (Reserved) 162
410. Requirements For Emergency Actions And Fire Drills. 162
411. -- 429. (Reserved) 163
430. Requirements For Furnishings, Equipment, and Supplies, and Basic Services. 163
431. -- 449. (Reserved) 164
450. Requirements For Food And Nutritional Care Services. 164
451. Menu And Diet Planning. 164
452. -- 454. (Reserved) 165
455. Food Supply. 165
456. -- 459. (Reserved) 165
460. Food Preparation And Service. 165
461. -- 509. (Reserved) 165
510. Requirements To Protect Residents From Abuse. 165
511. -- 514. (Reserved) 165
515. Requirements To Protect Residents From Exploitation. 166
516. -- 519. (Reserved) 166
520. Requirements To Protect Residents From Inadequate Care. 166
521. -- 524. (Reserved) 166
525. Requirements To Protect Residents From Neglect. 166
526. – 599. (Reserved) 166
600. Requirements For Staffing Standards. 166
601. -- 619. (Reserved) 167
620. Requirements For Training Of Facility Personnel. 167
621. -- 624. (Reserved) 167
625. Orientation Training Requirements. 167
626. -- 629. (Reserved) 167
630. Training Requirements For Facilities Admitting Residents With A Diagnosis Of Dementia, Mental Illness, Developmental Disability, Or Traumatic Brain Injury. 168
631. -- 639. (Reserved) 169
640. Continued Training Requirements. 169
641. Additional Training Related To Changes. 169
642. -- 644. (Reserved) 169
645. Assistance With Medications. 169
646. -- 899. (Reserved) 170
900. Enforcement Actions. 170
901. Enforcement Action Of Summary Suspension. 170
902. -- 909. (Reserved) 170
910. Enforcement Action Of A Consultant. 170
911. -- 919. (Reserved) 170
920. Enforcement Action Of Limit On Admissions. 170
921. -- 924. (Reserved) 170
925. Enforcement Action Of Civil Monetary Penalties. 170
926. -- 929. (Reserved) 172
930. Enforcement Action Of Temporary Management. 172
931. -- 934. (Reserved) 173
935. Enforcement Action Of A Provisional License. 173
936. -- 939. (Reserved) 173
940. Enforcement Action Of Revocation Of Facility License. 173
941. -- 999. (Reserved) 174

16.03.26 – Medicaid Plan Benefits
Docket No. 16-0326-2501 (New Chapter)
000. Legal Authority. ... 177
001. Scope. ... 177
002. Incorporation By Reference. ... 177
003. Background Check Requirements. ... 177
004. (Reserved) ... 178
005. Definitions: A Through H. ... 178
006. Definitions: I Through O. ... 180
007. Definitions: P Through Z. ... 182
008. – 009. (Reserved) ... 184
010. Medical Assistance Procedures. ... 184
011. Choice Of Providers. ... 184
012. Participant Responsibility. ... 184
013. – 019. (Reserved) ... 184
020. Individual Provider Requirements. ... 184
021. Provider Application Process. ... 185
022. Provider Agreements. ... 185
023. – 024. (Reserved) ... 186
025. Conditions For Payment. ... 186
026. Third-Party Liability. ... 187
027. – 029. (Reserved) ... 188
030. General Payment Procedures. ... 188
031. Handling Of Overpayments And Underpayments For Specified Providers. ... 190
032. – 034. (Reserved) ... 191
035. Records. ... 191
036. – 039. (Reserved) ... 191
040. Documentation For Audits. ... 191
041. – 044. (Reserved) ... 192
045. Related Party Transactions. ... 192
046. (Reserved) ... 192
047. Long-Term Care Facility Payment. ... 192
048. – 049. (Reserved) ... 192
050. NF And ICF/IID Reimbursement. ... 193
051. PCS And Aged And Disabled Waiver Service Cost Surveys. ... 200
052. Specialized Reimbursement: Certain HCBS And CHIS. ... 200
053. Accounting Treatment. ... 203
054. Specialized Reimbursement: Electronic Visit Verification (EVV). ... 203
055. Exception To The Related Organization Principle. ... 203
056. – 059. (Reserved) ... 204
060. Services, Treatments, And Procedures Not Covered By Medicaid. ... 204
061. Investigational Procedures Or Treatments. ... 205
062. – 069. (Reserved) ... 206
070. Hospital Services: Definitions. ... 206
071. Inpatient Hospital Services: Coverage And Limitations. ... 208
072. Inpatient Hospital Services: Procedural Requirements. ... 208
073. Inpatient Hospital Services: Provider Qualifications And Duties. ... 209
074. Hospital Services: Provider Reimbursement. ... 209
075. Inpatient Hospital Services: Quality Assurance. ... 213
076. – 079. (Reserved) ... 213
080. Outpatient Hospital Services: Definitions. ... 213
081. (Reserved) ... 213

082. Outpatient Hospital Services: Coverage And Limitations. 213
083. Outpatient Hospital Services: Procedural Requirements. 213
084. (Reserved) 214
085. Outpatient Hospital Services: Provider Reimbursement. 214
086. – 089. (Reserved) 214
090. – 091. (Reserved) 214
092. Ambulatory Surgical Center Services: Coverage And Limitations. 214
093. (Reserved) 214
094. Ambulatory Surgical Center Services: Provider Qualifications And Duties. 214
095. Ambulatory Surgical Center Services: Provider Reimbursement. 214
096. – 099. (Reserved) 214
100. Case Management. 214
101. Case Management: Participant Eligibility. 214
102. Case Management: Coverage And Limitations. 215
103. (Reserved) 215
104. Case Management: Provider Qualifications And Duties. 215
105. – 109. (Reserved) 215
110. Medical Services. 215
111. Medical Services: Participant Eligibility. 215
112. Medical Services: Coverage And Limitations. 215
113. Medical Services: Procedural Requirements. 216
114. Medical Services: Provider Qualifications And Duties 216
115. – 118. (Reserved) 216
119. Medical Services: Diagnostic Screening Clinics 216
120. Chiropractic Services: Definitions. 217
121. (Reserved) 217
122. Chiropractic Services: Coverage And Limitations. 217
123. – 130. (Reserved) 217
131. Diabetes Education And Training Services: Participant Eligibility. 217
132. Diabetes Education And Training Services: Coverage And Limitations. 217
133. Diabetes Education And Training Services: Procedural Requirements. 217
134. Diabetes Education And Training Services: Provider Qualifications And Duties. 217
135. – 139. (Reserved) 218
140. Licensed Midwife (LM) Services. 218
141. LM Services: Participant Eligibility. 218
142. LM Services: Coverage and Limitations. 218
143. – 145. (Reserved) 218
146. LM Services: Provider Quality Assurance Activities. 218
147. – 149. (Reserved) 218
150. Nutritional Services. 218
151. – 161. (Reserved) 218
162. Optometrist Services: Coverage And Limitations. 218
163. – 169. (Reserved) 218
170. Podiatrist Services: Definitions. 218
171. Podiatrist Services: Participant Eligibility. 219
172. Podiatrist Services: Coverage And Limitations. 219
173. – 179. (Reserved) 219
180. CHIS: Definitions. 219
181. CHIS: Eligibility Requirements. 219
182. CHIS: Coverage And Limitations. 220
183. CHIS: Procedural Requirements. 221
184. CHIS: Provider Qualifications And Duties. 222

185. CHIS: Provider Reimbursement. 224
186. CHIS: Quality Assurance. 224
187. – 189. (Reserved) 225
190. Preventive Health Assistance (PHA): Definitions. 225
191. Preventive Health Assistance (PHA): Participant Eligibility. 225
192. Preventive Health Assistance (PHA): Coverage And Limitations. 225
193. Preventive Health Assistance (PHA): Procedural Requirements. 226
194. (Reserved) 226
195. Preventive Health Assistance (PHA): Provider Reimbursement. 226
196. Early Intervention Services. 226
197. – 199. (Reserved) 226
200. Laboratory And Radiology Services: Definitions. 226
201. – 202. (Reserved) 226
203. Laboratory And Radiology Services: Coverage And Limitations. 226
204. Laboratory And Radiology Services: Provider Qualifications And Duties. 227
205. Laboratory And Radiology Services: Provider Reimbursement. 227
206. Laboratory And Radiology Services: Quality Assurance. 227
207. – 209. (Reserved) 227
210. Prescription Drugs: Definitions. 227
211. Prescription Drugs: Participant Eligibility. 227
212. Prescription Drugs: Coverage And Limitations. 227
213. Prescription Drugs: Procedural Requirements. 229
214. Prescription Drugs: Provider Qualifications And Duties. 230
215. Prescription Drugs: Provider Reimbursement. 230
216. – 219. (Reserved) 232
220. (Reserved) 233
221. Family Planning Services: Participant Eligibility. 233
222. Family Planning Services: Coverage And Limitations. 233
223. Family Planning Services: Procedural Requirements. 234
224. (Reserved) 234
225. Family Planning Services: Provider Reimbursement. 234
226. – 229. (Reserved) 234
230. (Reserved) 234
231. Behavioral Health Services: Participant Eligibility. 234
232. Behavioral Health Services: Coverage And Limitations. 234
233. Behavioral Health Services: Procedural Requirements. 234
234. Behavioral Health Services: Provider Qualifications And Duties. 234
235. Behavioral Health Services: Provider Reimbursement. 235
236. – 239. (Reserved) 235
240 – 241. (Reserved) 235
242. Home Health Services: Coverage And Limitations. 235
243. Home Health Services: Procedural Requirements. 235
244. Electronic Visit Verification (EVV). 236
245. (Reserved) 236
246. Home Health Services: Provider Reimbursement. 236
247. – 249. (Reserved) 236
250. Therapy Services: Definitions. 236
251. Therapy Services: Participant Eligibility. 237
252. Therapy Services: Coverage And Limitations. 237
253. Therapy Services: Procedural Requirements. 238
254. (Reserved) 238
255. Therapy Services: Provider Reimbursement. 238

256. Therapy Services: Quality Assurance Activities. ... 239
257. – 259. (Reserved) ... 239
260. Audiology Services. ... 239
261. (Reserved) ... 239
262. Audiology Services: Coverage And Limitations. ... 239
263. Audiology Services: Procedural Requirements. ... 239
264. – 269. (Reserved) ... 240
270. – 271. (Reserved) ... 240
272. DMEPOS: Coverage And Limitations. ... 240
273. DMEPOS: Procedural Requirements. ... 241
274. (Reserved) ... 241
275. DMEPOS: Provider Reimbursement. ... 241
276. DMEPOS: Quality Assurance. ... 242
277. – 279. (Reserved) ... 242
280. – 281. (Reserved) ... 242
282. Vision Services: Coverage And Limitations. ... 242
283. – 284. (Reserved) ... 243
285. Vision Services: Provider Reimbursement. ... 243
286. – 289. (Reserved) ... 243
290. Dental Services: Selective Contract For Dental Coverage ... 243
291. Dental Services: Definitions. ... 243
292. Dental Services: Participant Eligibility. ... 243
293. Dental Services: Coverage And Limitations. ... 243
294. Dental Services: Procedural Requirements. ... 243
295. Dental Services: Provider Qualifications And Duties ... 243
296. Dental Services: Provider Reimbursement. ... 244
297. Dental Services: Quality Assurance. ... 244
298. – 299. (Reserved) ... 244
300. FQHC And RHC Services: Definitions. ... 244
301. – 302. (Reserved) ... 244
303. FQHC And RHC Services: Coverage And Limitations. ... 244
304. – 305. (Reserved) ... 245
306. FQHC And RHC Services: Reimbursement Methodology. ... 245
307. FQHC And RHC: Rate Setting Methodology. ... 246
308. – 311. (Reserved) ... 247
312. Indian Health Service (IHS) Clinic Services: Coverage And Limitations. ... 247
313. – 314. (Reserved) ... 247
315. Indian Health Service (IHS) Clinic Services: Provider Reimbursement. ... 247
316. – 319. (Reserved) ... 247
320. School-Based Service: Definitions. ... 247
321. SBS: Participant Eligibility. ... 248
322. SBS: Service-Specific Participant Eligibility. ... 248
323. SBS: Coverage And Limitations. ... 249
324. SBS: Procedural Requirements. ... 251
325. SBS: Provider Qualifications And Duties. ... 252
326. SBS: Provider Reimbursement. ... 256
327. SBS: Quality Assurance And Improvement. ... 257
328. – 329. (Reserved) ... 257
330. (Reserved) ... 257
331. Emergency Transportation Services: Participant Eligibility. ... 257
332. Emergency Transportation Services: Coverage And Limitations. ... 257
333. Emergency Transportation Services: Procedural Requirements. ... 258

334. Emergency Transportation Services: Provider Qualifications And Duties. 258
335. Emergency Transportation Services: Provider Reimbursement. 258
336. – 339. (Reserved) 259
340. NEMT Services: Definitions. 259
341. NEMT Services: Duties Of The Transportation Broker. 260
342. NEMT Services: Coverage And Limitations. 260
343. NEMT Services: Reimbursement Methodology. 261
344. – 349. (Reserved) 261
350. EPSDT Services: Definitions. 261
351. EPSDT Services: Participant Eligibility. 261
352. EPSDT Services: Coverage And Limitations. 262
353. (Reserved) 262
354. EPSDT Services: Provider Qualifications And Duties. 262
355. – 359. (Reserved) 262
360. Pregnancy-Related Services: Definitions. 262
361. (Reserved) 262
362. Pregnancy-Related Services: Coverage And Limitations. 262
363. (Reserved) 263
364. Pregnancy-Related Services: Provider Qualifications And Duties. 263
365. Pregnancy-Related Services: Provider Reimbursement. 263
366. – 449. (Reserved) 263
450. – 451. (Reserved) 263
452. Organ Transplants: Coverage And Limitations. 263
453. – 454. (Reserved) 263
455. Organ Transplants: Reimbursement. 263
456. – 459. (Reserved) 263
460. PDN: Definitions. 264
461. PDN: Participant Eligibility. 264
462. PDN: Limitations. 264
463. (Reserved) 264
464. PDN: Provider Qualifications And Duties. 264
465. – 469. (Reserved) 265
470. NF: Definitions. 265
471. NF: Eligibility. 265
472. NF: Patient Liability. 266
473. NF: Coverage And Limitations. 266
474. NF: Procedural Responsibilities. 267
475. Preadmission Screening And Resident Review Program (PASRR). 268
476. NF: Eligibility Coordination And Specialized Service Needs. 268
477. NF: Prepayment Screen And Determination Of Entitlement To Medicaid Payment For NF Care And Services. 268
478. NF: Provider Qualifications And Duties. 268
479. – 480. (Reserved) 269
481. NF: Cost Limits. 269
482. NF: Rate Setting. 269
483. NF: Principle For Rate Setting. 269
484. NF: Rate Development. 269
485. NF: Out-Of-State Facilities. 269
486. NF: Distressed Facility. 269
487. NF: Reviews. 270
488. NF: Behavioral Care Unit (BCU) Rates. 270
489. NF: BCU Qualifications. 270

490. NF: BCU Eligible Days. 270
491. NF: Special Rates. 270
492. NF: Occupancy Adjustment Factor. 271
493. NF: Recapture Of Depreciation. 272
494. NF: Nurse Aide Training And Competency Evaluation Programs (NATCEPS). 272
495. NF: Payments For Temporary Absences. 272
496. – 499. (Reserved) 272
500. (Reserved) 272
501. ICF/IID: Participant Eligibility. 272
502. ICF/IID: Coverage And Limitations. 273
503. ICF/IID: Procedural Responsibilities. 274
504. ICF/IID: Provider Qualifications And Duties. 275
505. ICF/IID: Reimbursement. 275
506. (Reserved) 275
507. ICF/IID: Allowable Costs. 275
508. ICF/IID: Non-Allowable Costs. 276
509. (Reserved) 277
510. ICF/IID: Occupancy Adjustment Factor. 277
511. ICF/IID: Recapture Of Depreciation. 277
512. ICF/IID: Reporting System. 278
513. ICF/IID: Reporting System Principle And Application 278
514. (Reserved) 279
515. ICF/IID: Principle Prospective Rates. 279
516. ICF/IID: Property Reimbursement. 279
517. ICF/IID: Capped Cost. 279
518. (Reserved) 280
519. ICF/IID: Retrospective Settlement. 280
520. ICF/IID: Exempt Costs. 280
521. ICF/IID: Costs Excluded From Cap. 280
522. (Reserved) 281
523. ICF/IID: Property Rental Rate Reimbursement. 281
524. ICF/IID: Property Reimbursement Limitations. 282
525. ICF/IID: Special Rates. 282
526. – 529. (Reserved) 283
530. HCBS. 283
531. HCBS Exceptions. 283
532. (Reserved) 283
533. HCBS: Provider Qualifications And Duties. 283
534. (Reserved) 283
535. Exceptions To Residential Provider-Owned Or Controlled Setting Qualities. 284
536. HCBS Person-Centered Plan Requirements. 284
537. – 538. (Reserved) 284
539. HCBS: Participant Eligibility. 284
540. A&D Waiver Services: Definitions. 285
541. A&D Waiver Services: Eligibility. 285
542. A&D Waiver Services: Coverage And Limitations. 285
543. A&D Waiver Services: Procedural Requirements. 288
544. A&D Waiver Services: Provider Qualifications And Duties. 289
545. A&D Waiver Services: Provider Reimbursement. 291
546. – 548. (Reserved) 291
549. Transition Management. 291
550. PCS: Definitions. 292

551. PCS: Eligibility. 292
552. PCS: Coverage And Limitations. 293
553. PCS: Procedural Requirements. 294
554. PCS: Provider Qualifications And Duties. 295
555. PCS: Reimbursement. 295
556. PCS: Quality Improvement (QI). 296
557. – 559. (Reserved) 296
560. DD Services: Requirements. 296
561. DD Determination Standards: Participant Eligibility. 296
562. (Reserved) 299
563. DD Determination Standards: Test Instruments. 299
564. DD Services: Quality Improvement. 299
565. (Reserved) 299
566. DD Services: Administrative Appeals. 299
567. (Reserved) 299
568. Adult DD Services: Definitions. 299
569. Adult DD Services: Eligibility Determination. 300
570. (Reserved) 300
571. Adult DD Services: Coverage And Limitations. 300
572. Adult DD Services: Procedural Requirements. 300
573. Adult DD Services: Service Plan Requirements. 300
574. Adult DD Services: Provider Reimbursement. 302
575. – 579. (Reserved) 303
580. Children's DD HCBS State Plan Option: Definitions. 304
581. Children's DD HCBS State Plan Option: Eligibility Determination. 304
582. Children's DD HCBS State Plan Option: Coverage And Limitations. 304
583. Children's DD HCBS State Plan Option: Service Plan. 305
584. Children's DD HCBS State Plan Option: Procedural Requirements. 306
585. Children's DD HCBS State Plan Option: Provider Qualifications And Duties. 306
586. Children's DD HCBS State Plan Option: Reimbursement. 307
587. – 589. (Reserved) 307
590. Adult DD HCBS State Plan Option. 307
591. Adult DD HCBS State Plan Option: Eligibility. 307
592. Community Crisis Supports. 307
593. Community Crisis Supports: Coverage And Limitations. 307
594. – 599. (Reserved) 308
600. Developmental Therapy. 308
601. (Reserved) 308
602. Developmental Therapy: Coverage And Limitations. 308
603. Developmental Therapy: Individual Service Plan (ISP) Requirements. 308
604. Developmental Therapy: Individual Program Plan (IPP) Procedural Requirements. 309
605. Developmental Therapy: Procedural Requirements. 309
606. Developmental Therapy: Provider Qualifications And Duties. 311
607. Staffing Requirements. 311
608. – 609. (Reserved) 312
610. Adult DD Waiver Services. 312
611. Adult DD Waiver Services: Participant Eligibility. 312
612. Adult DD Waiver Services: Coverage And Limitations. 313
613. Adult DD Waiver Services: Procedural Requirements. 315
614. Adult DD Waiver Services: Provider Qualifications And Duties. 316
615. Adult DD Waiver Services: Provider Reimbursement. 317
616. – 619. (Reserved) 317

620. Health Home. ... 317
621. Health Home: Eligibility Requirements. ... 317
622. Health Home: Coverage And Limitations. ... 317
623. Health Home: Procedural Requirements. ... 317
624. Health Home: Provider Qualifications And Duties. ... 317
625. Health Home: Provider Reimbursement. ... 318
626. – 629. (Reserved) ... 318
630. Service Coordination: Definitions. ... 318
631. Service Coordination: Participant Eligibility. ... 318
632. Service Coordination: Coverage And Limitations. ... 318
633. Service Coordination: Procedural Requirements. ... 320
634. Service Coordination: Provider Qualifications And Duties. ... 320
635. Service Coordination: Plan Development – Assessment. ... 321
636. Service Coordination Plan. ... 321
637. Service Coordination: Reimbursement. ... 321
638. – 639. (Reserved) ... 322
640. YES HCBS State Plan Option: Independent Assessment. ... 322
641. YES HCBS State Plan Option: Redetermination. ... 322
642. YES HCBS State Plan Option: Coverage And Limitations. ... 322
643. – 649. (Reserved) ... 322
650. Hospice. ... 323
651. Hospice: Definitions. ... 323
652. Hospice: Eligibility. ... 323
653. Hospice: Coverage And Limitations. ... 323
654. Hospice: Procedural Requirements. ... 323
655. Hospice: Provider Qualifications And Duties. ... 324
656. Hospice: Reimbursement. ... 324
657. Hospice: Inpatient Payment Limitations. ... 325
658. Hospice: Physician Payments. ... 325
659. Hospice: Reimbursement Cap. ... 326
660. Hospice: Patient Liability. ... 326
661. – 959. (Reserved) ... 327
960. Medicare Savings Program. ... 327
961. – 969. (Reserved) ... 327
970. Managed Care For Duals. ... 327
971. Managed Care For Duals: Definitions. ... 327
972. Managed Care For Duals: Program Authority. ... 328
973. Managed Care For Duals: Eligibility And Enrollment. ... 328
974. Managed Care For Duals: Coverage And Limitations. ... 328
975. – 979. (Reserved) ... 328
980. (Reserved) ... 328
981. Liens And Estate Recovery: Definitions. ... 328
982. Liens And Estate Recovery: Notification To Department. ... 329
983. Liens And Estate Recovery: Lien During Lifetime Of Participant. ... 329
984. Liens And Estate Recovery: Requirements For Estate Recovery. ... 331
985. Liens And Estate Recovery: Limitations And Exclusions. ... 332
986. Liens And Estate Recovery: Request For Notice. ... 333
987. – 989. (Reserved) ... 333
990. Participant Utilization Control Program. ... 333
991. Lock-In Defined. ... 334
992. Department Evaluation For Lock-In. ... 334
993. Criteria For Lock-In. ... 334

994. Lock-In Participant Notification. 334
995. Lock-In Procedures. 334
996. Penalties For Lock-In Noncompliance. 335
997. Appeal Of Lock-In. 335
998. Recipient Explanation Of Medicaid Benefits (REOMBs). 335
999. (Reserved) 335

16.05.01 – Use and Disclosure of Department Records
Docket No. 16-0501-2501 (ZBR Chapter Rewrite)
000. Legal Authority. 338
001. Scope. 338
002. -- 00610. (Reserved) 338
007. District Court Appeals, Complaints And Requests For Reconsideration. 339
008. -- 009. (Reserved) 339
010. Definitions. 339
011. Definitions For Vital Statistics. 340
012. -- 049. (Reserved) 341
050. Consent To Gather, Use And Disclose Information. 341
051. Authorization For The Use And Disclosure Of Confidential Information. 342
052. -- 074. (Reserved) 342
075. Use And Disclosure Of Confidential Information. 342
076. -- 099. (Reserved) 343
100. Exceptions To Requirement For Authorization. 343
101. Abuse, Neglect, Or Domestic Violence. 345
102. Victim Of Other Crime. 346
103. Serious Threat To Health Or Safety. 346
104. Reporting Of Crime On Premises. 346
105. Reporting Crime In Emergencies. 346
106. -- 124. (Reserved) 346
125. Access To An Individual's Own Record. 346
126. -- 149. (Reserved) 347
150. Amendment Of Record. 347
151. -- 174. (Reserved) 347
175. Report Of Disclosures Of Health Information. 347
176. -- 189. (Reserved) 348
190. Records Of Decedents. 348
191. Data For Research Or Other Purposes. 348
192. -- 199. (Reserved) 348
200. Abortion For Minors. 348
201. Abuse, Neglect Or Domestic Violence. 349
202. Adoption. 349
203. -- 209. (Reserved) 349
210. Child Protection. 349
211. Children's Mental Health. 349
212. -- 219. (Reserved) 349
220. Hard To Place Children. 349
221. Hospital Records. 349
222. Human Resources. 350
223. Infant/toddler Program. 350
224. -- 229. (Reserved) 350
230. Medical Care. 350
231. -- 239. (Reserved) 350
240. Mental Illness. 350

241. Minor's Consent Regarding Infectious, Contagious Or Communicable Disease. 350
242. Specific Requirements - Protection And Advocacy Agencies. 350
243. -- 249. (Reserved) 350
250. Substance Abuse. 350
251. -- 259. (Reserved) 350
260. Termination Of Parental Rights. 350
261. -- 269. (Reserved) 350
270. Venereal Diseases. 350
271. -- 279. (Reserved) 351
280. Vital Statistics -- Verification Of Data. 351
281. Vital Statistics: Disclosure For Research, Public Health Or Statistical Purposes. 351
282. Vital Statistics: Registry Of Putative Fathers. 351
282. (Reserved) 351
283. Vital Statistics: Procedures For Requesting Information. 351
284. Women, Infants And Children (WIC) Program. 351
2854. -- 999. (Reserved) 351

IDAPA 34 – SECRETARY OF STATE

34.03.01 – Rules Implementing the Sunshine Law

Docket No. 34-0301-2501

000. Legal Authority. 353
011. Forms. 353

LEGAL NOTICE

Summary of Proposed Rulemakings

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 required information concerning their intent to change or make new the following rules in the latest publication of the state Administrative Bulletin.

The proposed rule public hearing request deadline is June 18, 2025, unless otherwise posted.
The proposed rule written comment submission deadline is June 25, 2025, unless otherwise posted.
(Temp & Prop) indicates the rulemaking is both Temporary and Proposed.
(*PH) indicates that a public hearing has been scheduled.

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE
PO Box 83720, Boise, ID 83720-0036

16-0210-2501, Idaho Reportable Diseases. (*PH) Zero-Based Regulation (ZBR) Chapter Rewrite governs the reporting, control, and prevention of reportable diseases and conditions and requirements to prevent transmission of health hazards within Idaho.

16-0227-2501, Idaho Radiation Control Rules. (*PH) ZBR Chapter Rewrite defines licensure, education, quality assurance, and safety requirements for X-ray machines operated within the state.

16-0321-2501, Developmental Disabilities Agencies (DDA). (*PH) Chapter Rewrite consolidates IDAPAs 16.03.21 and 16.04.17 to assist the Department and providers with ensuring the health and safety of the vulnerable individuals that Developmental Disabilities Agencies, Residential Habilitation Agencies, and Adult Residential Care Facilities may serve.

16-0322-2501, Residential Assisted Living Facilities. (*PH) ZBR Chapter Rewrite sets standards for providing services that maintain a safe and healthy environment for residential assisted living facilities.

16-0326-2501, Medicaid Plan Benefits. (Temp & Prop) (*PH) New Chapter combines components of both 16.03.09, Medicaid Basic Plan Benefits, and 16.03.10, Medicaid Enhanced Plan Benefits, eliminated by the 2025 Legislature, into a single streamlined document. This consolidated new chapter contains the general provisions regarding the administration of Medicaid, including provider procurement and reimbursement.

16-0417-2501, Residential Habilitation Agencies. ZBR Chapter Repeal moves and consolidates necessary provisions under docket 16-0321-2501.

16-0501-2501, Use and Disclosure of Department Records. (*PH) ZBR Chapter Rewrite governs the use and disclosure of information maintained by the Department, in compliance with applicable state and federal laws, and federal regulations.

IDAPA 34 – SECRETARY OF STATE
PO Box 83720, Boise, ID 83720-0080

34-0301-2501, Rules Implementing the Sunshine Law. Amendments remove from rule registration and reporting requirements related to lobbyists which have been moved to statute as a result of recently enacted legislation.

NOTICE OF ADOPTED / AMENDED PROCLAMATION(S)

IDAPA 13 – IDAHO FISH AND GAME COMMISSION

13-0000-2500P3, Establishing Seasons and Limits for Hunting, Fishing, and Trapping in Idaho

NOTICE OF ADOPTION OF TEMPORARY RULE ONLY

IDAPA 13 – IDAHO DEPARTMENT OF FISH AND GAME

13-0104-2501, Rules Governing Licensing

NOTICES OF INTENT TO PROMULGATE RULES – NEGOTIATED RULEMAKING

(Please see the Administrative Bulletin for dates and times of meetings and other participant information)

IDAPA 08 – STATE BOARD OF EDUCATION
08-0113-2501, Rules Governing the Opportunity Scholarship Program
08-0202-2501, Rules Governing Uniformity
08-0203-2501, Rules Governing Thoroughness
08-0203-2502, Rules Governing Thoroughness
08-0205-2501, Rules Governing Pay for Success Contracting

IDAPA 11 – IDAHO STATE POLICE
11-0601-2501, Rules Governing Civil Asset Forfeiture Reporting
11-1001-2501, Rules Governing Idaho Public Safety and Security Information System
11-1002-2501, Rules Governing State Criminal History Records and Crime Information
11-1003-2501, Rules Governing the Sex Offender Registry

IDAPA 45 – IDAHO HUMAN RIGHTS COMMISSION
45-0101-2501, Rules of the Idaho Human Rights Commission

IDAPA 55 – DIVISION OF CAREER TECHNICAL EDUCATION
55-0103-2501, Rules of Career Technical Centers

IDAPA 62 – OFFICE OF ADMINISTRATIVE HEARINGS
62-0101-2501, Idaho Rules of Administrative Procedure

Please refer to the Idaho Administrative Bulletin **June 4, 2025, Volume 25-6**, for the notices and text of all rulemakings, proclamations, negotiated rulemaking and public hearing information and schedules, executive orders of the Governor, and agency contact information.

***Electronic issues of the Idaho Administrative Bulletin can be viewed at* www.adminrules.idaho.gov/**

Office of the Administrative Rules Coordinator, Division of Financial Management
P.O. Box 83720, Boise, ID 83720-0032
Phone: 208-334-3900; Email: **adminrules@dfm.idaho.gov**

CUMULATIVE RULEMAKING INDEX
OF IDAHO ADMINISTRATIVE RULES

Office of the Administrative Rules Coordinator
Division of Financial Management
Office of the Governor

July 1, 1993 – Present

CUMULATIVE RULEMAKING INDEX OF IDAHO ADMINISTRATIVE RULES

This index provides a history of all agency rulemakings beginning with the first Administrative Bulletin in July 1993 to the most recent Bulletin publication. It tracks all rulemaking activities on each chapter of rules by the rulemaking docket numbers and includes negotiated, temporary, proposed, pending and final rules, public hearing notices, vacated rulemaking notices, notice of legislative actions taken on rules, and executive orders of the Governor.

ABRIDGED RULEMAKING INDEX
OF IDAHO ADMINISTRATIVE RULES

(Index of Current and Active Rulemakings)

Office of the Administrative Rules Coordinator
Division of Financial Management

April 10, 2024 – June 4, 2025

(PLR 2025) – Final Effective Date Is Pending Legislative Review in 2025
(eff. date)L – Denotes Adoption by Legislative Action
(eff. date)T – Temporary Rule Effective Date
SCR # – denotes the number of a Senate Concurrent Resolution (Legislative Action)
HCR # – denotes the number of a House Concurrent Resolution (Legislative Action)

(This Abridged Index includes all active rulemakings.)

IDAPA 02 – IDAHO DEPARTMENT OF AGRICULTURE

02.01.03, Airborne Control of Unprotected or Predatory Animals Rules
02-0103-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.01.05, Rules Governing Certificates of Free Sale
02-0105-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.01.08, Rules Governing Grizzly Bear and Wolf Depredation
02-0108-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking (New Chapter), Bulletin Vol. 25-5

02-0108-2401 Adoption of Temporary Rule, Bulletin Vol. 24-12 (eff. 11-12-24)T

02.02.05, Rules Governing Stone Fruit Grades
02-0205-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.02.07, Rules Governing Bulk Permits and Retail Sale of Potatoes
02-0207-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.02.11, Rules Governing Eggs and Egg Products
02-0211-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.02.12, Bonded Warehouse Rules
02-0212-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
02-0212-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
02-0212-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

02.02.14, Rules for Weights and Measures
02-0214-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02-0214-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0214-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10

02.03.01, Rules Governing Pesticide Management Plans for Ground Water Protection
02-0301-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
02-0301-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
02-0301-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

02.03.03, Rules Governing Pesticide and Chemigation Use and Application
02-0303-2402 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0303-2402 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T

02-0303-2401 Adoption of Temporary Rule, Bulletin Vol. 24-5 (eff. 4-22-24)T ***[expires 7-1-24]***

02.04.03, Rules Governing Animal Industry
02-0403-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
02-0403-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
02-0403-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

02.04.05, Rules Governing Grade A Milk and Manufacture Grade Milk
02-0405-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0405-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10

02.04.15, Rules Governing Beef Cattle Animal Feeding Operations
02-0415-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0415-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
02-0415-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

02.04.19, Rules Governing Domestic Cervidae

02-0419-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0419-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
02-0419-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

02.04.20, Rules Governing Brucellosis

02-0420-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.04.24, Rules Governing Tuberculosis

02-0424-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.04.26, Rules Governing the Public Exchange of Livestock

02-0426-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.05.01, Rules Governing Produce Safety

02-0501-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
02-0501-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
02-0501-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

02.06.01, Rules Governing the Production and Distribution of Seed

02-0601-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.06.02, Rules Governing Registrations and Licenses

02-0602-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0602-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10

02.06.09, Rules Governing Invasive Species and Noxious Weeds

02-0609-2406 Adoption of Temporary Rule, Bulletin Vol. 24-12 (eff. 11-9-24)T

*02-0609-2405 Adoption of Temporary Rule, Bulletin Vol. 24-11 (eff. 10-7-24)T [**superseded**]*

*02-0609-2404 Adoption of Temporary Rule, Bulletin Vol. 24-10 (eff. 9-26-24)T [**superseded**]*

*02-0609-2403 Adoption of Temporary Rule, Bulletin Vol. 24-8 (eff. 6-28-24)T [**superseded**]*

02-0609-2402 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0609-2402 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
02-0609-2402 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

*02-0609-2401 Adoption of Temporary Rule, Bulletin Vol. 24-4 (eff. **sine die** 2024)T [**superseded**]*

02.06.33, Organic Food Products Rules

02-0633-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
02-0633-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10

02.07.01, Rules of the Idaho Hop Growers' Commission

02-0701-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

02.08.01, Sheep and Goat Rules of the Idaho Sheep and Goat Health Board

02-0801-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
02-0801-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
02-0801-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-6

IDAPA 04 – OFFICE OF THE ATTORNEY GENERAL

04.11.01, Idaho Rules of Administrative Procedure of the Attorney General

44-0000-2400 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA chapter 04.11.01 – Bulletin Vol. 24-7

IDAPA 08 – IDAHO STATE BOARD OF EDUCATION AND STATE DEPARTMENT OF EDUCATION

08.01.11, Registration of Postsecondary Educational Institutions and Proprietary Schools
08-0111-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
08-0111-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T

08.01.13, Rules Governing the Opportunity Scholarship Program
08-0113-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-6

08-0113-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
08-0113-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
08-0113-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-6

08.01.15, Rules Governing the Firearms Safety Grant Program
08-0115-2401 Notice of Intent to Promulgate Rules (New Chapter) – Negotiated Rulemaking, Bulletin Vol. 24-6

08.02.01, Rules Governing Administration
08-0201-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
08-0201-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T

08.02.02, Rules Governing Uniformity
08-0202-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-6

08-0202-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
08-0202-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
08-0202-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-6

08.02.03, Rules Governing Thoroughness
08-0203-2502 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-6

08-0203-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-6

08-0203-2403 Adoption of Temporary Rule, Bulletin Vol. 24-10 (eff. 8-21-24)T

08-0203-2402 Adoption of Temporary Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T

08-0203-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
08-0203-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
08-0203-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-6

08.02.04, Rules Governing Public Charter Schools
08-0204-2400 Notice of Revocation of Final Rule, Bulletin Vol. 24-3

08.02.05, Rules Governing Pay for Success Contracting
08-0205-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-6

08.04.01, Rules of the Idaho Digital Learning Academy
08-0401-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
08-0401-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
08-0401-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-6

IDAPA 09 – IDAHO DEPARTMENT OF LABOR

09.01.01, Rules of Administrative Procedure of the Department of Labor
09-0101-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
09-0101-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
09-0101-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

09.01.08, Rules on Disclosure of Employment Security Information
09-0108-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8

09.01.30, Unemployment Insurance Benefits Administration Rules

09-0130-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
09-0130-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
09-0130-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

09.01.35, Unemployment Insurance Tax Administration Rules

09-0135-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
09-0135-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
09-0135-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

09.05.03, Rules for Determining Bargaining Representatives

09-0503-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8

IDAPA 11 – IDAHO STATE POLICE

Idaho State Brand Board

11.02.01, Rules of the Idaho State Brand Board

11-0201-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7 (terminated by agency)

Idaho State Police Forensic Services

11.03.01, Rules Governing Alcohol Testing

11-0301-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
11-0301-2401 Notice of Public Hearing and Extension of Written Comment Period, Bulletin Vol. 24-11
11-0301-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
11-0301-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8

Idaho State Racing Commission

11.04.01, Rules Governing the Idaho State Racing Commission

44-0000-2400 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA 11.04.01 – Bulletin Vol. 24-7

Alcohol Beverage Control Bureau

11.05.01, Rules Governing Alcohol Beverage Control

11-0501-2403 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
11-0501-2403 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
11-0501-2403 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

11-0501-2402 Adoption of Temporary Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T

*11-0501-2401 Adoption of Temporary Rule, Bulletin Vol. 24-4 (eff. **sine die** 2024)T **[expires 7-1-24]***

11.06.01, Rules Governing Civil Asset Forfeiture Reporting

11-0601-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-6

11.10.01, Rules Governing Idaho Public Safety and Security Information System

11-1001-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-6

*11-1001-2401 Adoption of Temporary (Fee) Rule, Bulletin Vol. 24-6 (eff. 4-24-24)T **[expires 7-1-24]***

11.10.02, Rules Governing State Criminal History Records and Crime Information

11-1002-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-6

11.10.03, Rules Governing the Sex Offender Registry

11-1003-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-6

Peace Officer Standards and Training (POST) Council

11.11.01, Rules of the Idaho Peace Officer Standards and Training Council

11-1101-2401 Adoption of Pending Rule, Bulletin Vol. 24-10 (PLR 2025)
11-1101-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-7 (eff. 6-7-24)T

Idaho State Police Commercial Vehicle Safety

11.13.01, The Motor Carrier Rules

11-1301-2401 *Notice of Rescission of Temporary Rule and Vacation of Proposed Rulemaking, Bulletin Vol. 24-11*
11-1301-2401 *Notice of Temporary and Proposed Rule, Bulletin Vol. 24-8 (eff. 7-1-24)T*

IDAPA 13 – IDAHO FISH AND GAME COMMISSION

Establishing Seasons and Limits for Hunting, Fishing, and Trapping in Idaho

13-0000-2500P3 Notice of Adopted / Amended Proclamations for Calendar Year 2025, Bulletin Vol. 25-6
13-0000-2500P2 Notice of Adopted / Amended Proclamations for Calendar Year 2025, Bulletin Vol. 25-5
13-0000-2500P1 Notice of Adoption of Proclamation for Calendar Year 2025, Bulletin Vol. 25-2

13-0000-2400P7 Notice of Adopted / Amended Proclamations for Calendar Year 2024, Bulletin Vol. 24-12
13-0000-2400P6 Notice of Adopted / Amended Proclamations for Calendar Year 2024, Bulletin Vol. 24-9
13-0000-2400P5 Notice of Adopted / Amended Proclamations for Calendar Year 2024, Bulletin Vol. 24-8
13-0000-2400P4 Notice of Adopted / Amended Proclamations for Calendar Year 2024, Bulletin Vol. 24-7
13-0000-2400P3 Notice of Adopted / Amended Proclamations for Calendar Year 2024, Bulletin Vol. 24-6
13-0000-2400P2 Notice of Adopted / Amended Proclamations for Calendar Year 2024, Bulletin Vol. 24-5
13-0000-2400P1 Notice of Adoption of Proclamation for Calendar Year 2024, Bulletin Vol. 24-2

13.01.02, Rules Governing Mandatory Education, Mentored Hunting, and Shooting Ranges

13-0102-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
13-0102-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-10 (eff. 1-1-25)T

13.01.03, Public Use of Lands Owned or Controlled by the Department of Fish and Game

13-0103-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

13.01.04, Rules Governing Licensing

13-0104-2501 Adoption of Temporary Rule, Bulletin Vol. 25-6 (eff. 5-22-25)T

13-0104-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

13.01.07, Rules Governing Taking of Wildlife

13-0107-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
13-0107-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10

13.01.08, Rules Governing Taking of Big Game Animals

13-0108-2501 Adoption of Temporary Rule, Bulletin Vol. 25-5 (eff. 4-15-25)T

13-0108-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

13.01.11, Rules Governing Fish

13-0111-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
13-0111-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
13-0111-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

13.01.16, Trapping of Wildlife and Taking of Furbearing Animals

13-0116-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

13.01.17, Rules Governing Use of Bait for Hunting Big Game Animals

13-0117-2402 Adoption of Temporary Rule, Bulletin Vol. 24-10 (eff. 9-1-24)T ***[expires sine die 2025]***

13-0117-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

13.01.19, Rules for Selecting, Operating, Discontinuing, and Suspending Vendors

13-0119-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

IDAPA 15 – OFFICE OF THE GOVERNOR

Executive Orders of the Governor

Executive Order No. 2025-04 Make Forests Healthy Again Act, Bulletin Vol. 25-5
Executive Order No. 2025-03 Border Security and Immigration Enforcement Act, Bulletin Vol. 25-3
Executive Order No. 2025-02 Idaho Strategic Permitting, Efficiency and Economic Development (SPEED) Act, Bulletin Vol. 25-2
Executive Order No. 2025-01 Gone With the Lava Ridge Wind Project Act, Bulletin Vol. 25-2

Executive Order No. 2024-13A Continuing the Idaho Criminal Justice Commission, Bulletin Vol. 25-4
Executive Order No. 2024-12 Continuing a System for Allocating Volume Cap in the State Consistent With Provisions of Title 50, Chapter 28, Idaho Code, and the U.S. Internal Revenue Code of 1986, Bulletin Vol. 25-3
Executive Order No. 2024-11 Phone Free Learning Act, Bulletin Vol. 24-11
Executive Order No. 2024-10 Continuing the Idaho Strategic Energy Alliance Repealing and Replacing Executive Order 2020-18, Bulletin Vol. 24-11
Executive Order No. 2024-09 Continuing the Office of Energy and Mineral Resources Within the Office of the Governor, Bulletin Vol. 24-11
Executive Order No. 2024-08 Defending Women's Sports Act, Bulletin Vol. 24-9
Executive Order No. 2024-07 Only Citizens Will Vote Act, Bulletin Vol. 24-8
Executive Order No. 2024-06 Protecting Idaho Water Sovereignty Act, Bulletin Vol. 24-7
Executive Order No. 2024-05 Promoting Families and Protecting Children, Bulletin Vol. 24-7
Executive Order No. 2024-04 Operation Esto Perpetua, Bulletin Vol. 24-5
Executive Order No. 2024-03 Continuing the Juvenile Justice Commission, Bulletin Vol. 24-5
Executive Order No. 2024-02 Continuing the Workforce Development Council, Bulletin Vol. 24-5
Executive Order No. 2024-01 Continuing the Idaho Behavioral Health Council, Bulletin Vol. 24-5

Executive Order No. 2023-05 Establishing the Governor's Commission on Service and Volunteerism, Bulletin Vol. 24-11
Executive Order No. 2023-04 Directing the Idaho Department of Health and Welfare to Support Idaho Suicide Prevention Action Collective in Monitoring and Implementing the Idaho Suicide Prevention Plan, Bulletin Vol. 24-11

Executive Order Retrospective Spanning Years 1938-1995, Bulletin Vol. 24-3SE

State of the State and Budget Addresses of the Governor

State of the State and Budget Addresses Retrospective Spanning Years 1890-2024, Bulletin Vol. 24-4SE

Idaho Commission for the Blind and Visually Impaired

15.02.30, Business Enterprise Program

15-0230-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-11
15-0230-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-9

Idaho Forest Products Commission

15.03.01, Rules of Administrative Procedure of the Idaho Forest Products Commission

15-0301-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

Division of Human Resources and Personnel Commission

15.04.01, Rules of the Division of Human Resources and Idaho Personnel Commission

44-0000-2401 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA 15.04.01 – Bulletin Vol. 24-8

Idaho Military Division – Idaho Public Safety Communications Commission

15.06.01, Rules Governing the Idaho Public Safety Communications Commission

15-0601-2501 Notice of Temporary and Proposed Rule, Bulletin Vol. 25-5 (eff. 5-1-25)T

15.06.05, Hazardous Substance Response Rules

15-0605-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8-terminated

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.01, Emergency Medical Services

16-0101-2401 Adoption of Pending Rule (New Chapter), Bulletin Vol. 24-11 (PLR 2025)
16-0101-2401 Notice of Proposed Rulemaking (New Chapter), Bulletin Vol. 24-9

16.01.02, Emergency Medical Services (EMS) – Rule Definitions

16-0102-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0102-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.01.03, Emergency Medical Services (EMS) -- Agency Licensing Requirements

16-0103-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0103-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.01.05, Emergency Medical Services (EMS) -- Education, Instructor, & Examination Requirements

16-0105-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0105-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.01.07, Emergency Medical Services (EMS) – Personnel Licensing Requirements

16-0107-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0107-2401 Notice of Proposed Rulemaking (ZBR Chapter Repeal), Bulletin Vol. 24-9
16-0107-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

16.01.12, Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions

16-0112-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0112-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.02.01, Idaho Time Sensitive Emergency System Council

16-0201-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0201-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.02.02, Idaho Emergency Medical Services (EMS) Physician Commission

16-0202-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0202-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.02.10, Idaho Reportable Diseases

16-0210-2501 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 25-6
16-0210-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16.02.12, Newborn Screening

16-0212-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
16-0212-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9

16.02.13, State of Idaho Drinking Water Laboratory Certification Program

16-0213-2401* Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-11 (PLR 2025)
**Changes chapter name from: "State of Idaho Drinking Water Laboratory Certification Program"*
16-0213-2401* Notice of Public Hearing and Extension of Written Comment Period, Bulletin Vol. 24-10
16-0213-2401* Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-9
16-0213-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

16.02.27, Idaho Radiation Control Rules

16-0227-2501 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 25-6
16-0227-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16.03.08, Temporary Assistance for Families in Idaho (TAFI) Program

16-0308-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16.03.09, Medicaid Basic Plan Benefits

16-0309-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
16-0309-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
16-0309-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

16.03.10, Medicaid Enhanced Plan Benefits

16-0310-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16.03.11, Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/IID)

16-0311-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

16.03.13, Consumer-Directed Services

16-0313-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
16-0313-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
16-0313-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

16.03.14, Hospitals

16-0314-2401 Adoption of Pending Rule (ZBR Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0314-2401 Notice of Proposed Rulemaking (ZBR Chapter Repeal), Bulletin Vol. 24-9
16-0314-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5

16-0314-2301 OARC Corrected Omnibus Notice of Legislative Action – Extension of Temporary Rule, Bulletin Vol. 24-9 (eff. 7-1-24)
16-0314-2301 OARC Omnibus Notice of Legislative Action – Extension of Temporary Rule, Bulletin Vol. 24-8 (eff. 11-14-23)T
16-0314-2301 Adoption of Temporary Rule, Bulletin Vol. 23-12 (eff. 11-14-23)T

16.03.21, Developmental Disabilities Agencies (DDA)

16-0321-2501* Notice of Proposed Rulemaking (Chapter Rewrite), Bulletin Vol. 25-6
**Changes chapter name from: "Developmental Disabilities Agencies (DDA)"*

16.03.22, Residential Assisted Living Facilities

16-0322-2501 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 25-6
16-0322-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16.03.26, Medicaid Plan Benefits

16-0326-2501 Notice of Temporary and Proposed Rule (New Chapter), Bulletin Vol. 25-6 (eff. 7-1-25)T

16.04.07, Fees for State Hospital North and State Hospital South

16-0407-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0407-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.04.17, Residential Habilitation Agencies

16-0417-2501 Notice of Proposed Rulemaking (ZBR Chapter Repeal), Bulletin Vol. 25-6
16-0417-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16.04.18, Children's Agencies and Residential Licensing

16-0418-2401 Adoption of Pending Rule, Bulletin Vol. 24-9 (PLR 2025)
16-0418-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T

16.05.01, Use and Disclosure of Department Records

16-0501-2501 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 25-6
16-0501-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16-0501-2401 Adoption of Pending Rule, Bulletin Vol. 24-11 (PLR 2025)
16-0501-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-9 (eff. 8-6-24)T

16.05.03, Contested Cases Proceedings and Declaratory Rulings

44-0000-2400 *Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA 16.05.03 – Bulletin Vol. 24-7*

(MOVED AND REDESIGNATED) *16.05.04, Domestic Violence Council Grants*

16-0504-2400 **IDAPA 16.05 – IDAHO COUNCIL ON DOMESTIC VIOLENCE AND VICTIM ASSISTANCE** – Notice of Assignment of New IDAPA Designation Number – Redesignated from ***IDAPA 16, Title 05, Chapter 04*** to ***IDAPA 63, Title 05, Chapter 04*** – Bulletin Vol. 24-6 (eff. 7-1-24)

16.06.01, Child and Family Services

16-0601-2405 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
16-0601-2405 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-12

16-0601-2404 Adoption of Temporary Rule, Bulletin Vol. 24-9 (eff. 8-6-24)T

16-0601-2403 Adoption of Temporary Rule, Bulletin Vol. 24-7 (eff. 6-5-24)T

16-0601-2402 Notice of Vacation of Proposed Rulemaking, Bulletin Vol. 24-9
16-0601-2402 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-6 (eff. 4-17-24)T

16-0601-2401 *Vacation of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12*
16-0601-2401 *Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)*
16-0601-2401 *Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9*
16-0601-2401 *Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4*

16.06.02, Foster Care Licensing

16-0602-2500 Notice of Revocation of Final Rule, Bulletin Vol. 25-5

16-0602-2403 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
16-0602-2403 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-9 (eff. 8-15-24)T

16-0602-2402 Adoption of Pending Rule (Chapter Rewrite), Bulletin Vol. 24-9 (PLR 2025)
16-0602-2402 Notice of Temporary and Proposed Rule (Chapter Rewrite), Bulletin Vol. 24-7 (eff. 7-1-24)T

16-0602-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-9 (PLR 2025)
16-0602-2401 Notice of Temporary and Proposed Rule (Chapter Repeal), Bulletin Vol. 24-7 (eff. 7-1-24)T

16.06.03, Daycare Licensing

16-0603-2401 Adoption of Temporary Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T ***[expires sine die 2025]***

16.06.05, Alleged Medical Neglect of Handicapped Infants

16-0605-2401 Adoption of Pending Rule (Chapter Repeal), Bulletin Vol. 24-11 (PLR 2025)
16-0605-2401 Notice of Proposed Rulemaking (Chapter Repeal), Bulletin Vol. 24-9

16.06.12, Idaho Child Care Program (ICCP)

16-0612-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

16.07.17, Substance Use Disorders Services

16-0717-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
16-0717-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-11

16.07.33, Adult Mental Health Services

16-0733-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
16-0733-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-11

16.07.37, Children's Mental Health Services

16-0737-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
16-0737-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
16-0737-2401 (Second) Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-3
16-0737-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-2

IDAPA 17 – INDUSTRIAL COMMISSION

17.01.01, Administrative Rules Under the Worker's Compensation Law

17-0101-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)

17-0101-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
17-0101-2301 (Second) Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-5
17-0101-2301 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 23-11

IDAPA 18 – DEPARTMENT OF INSURANCE

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapters 05, 06, 11-15; & Title 06, Chapter 05 – Bulletin Vol. 25-5

18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 01, Chapter 01; Title 03, Chapters 02-04; Title 04, Chapter 03; Title 05, Chapter 01; Title 06, Chapter 06; and Title 07, Chapters 04, 05 – Bulletin Vol. 24-7

18.01.01, Rule to Implement the Privacy of Consumer Financial Information

18-0101-2401 *Notice of Vacation of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-11*
18-0101-2401 *Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9*
18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** *– Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 01, Chapter 01 – Bulletin Vol. 24-7*

18.03.02, Life Settlements

18-0302-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
18-0302-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 02 – Bulletin Vol. 24-7

18.03.03, Variable Contracts

18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 03 – Bulletin Vol. 24-7

18.03.04, Replacement of Life Insurance and Annuities

18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 04 – Bulletin Vol. 24-7

18.04.03, Advertisement of Disability (Accident and Sickness) Insurance

18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 03 – Bulletin Vol. 24-7

18.04.05, Self-Funded Health Care Plans Rule

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 05 – Bulletin Vol. 25-5

18.04.06, Governmental Self-Funded Employee Health Care Plans Rule

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 06 – Bulletin Vol. 25-5

18.04.11, Long-Term Care Insurance Minimum Standards

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 11 – Bulletin Vol. 25-5

18.04.12, The Small Employer Health Insurance and Availability Act

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 12 – Bulletin Vol. 25-5

18.04.13, The Individual Health Insurance Availability Act

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 13 – Bulletin Vol. 25-5

18.04.14, Coordination of Benefits

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 14 – Bulletin Vol. 25-5

18.04.15, Rules Governing Short-Term Health Insurance Coverage

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 04, Chapter 15 – Bulletin Vol. 25-5

18-0415-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

18.05.01, Rules for Title Insurance Regulation

18-0501-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
18-0501-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 05, Chapter 01 – Bulletin Vol. 24-7

18.06.05, Managing General Agents

18-ZBRR-2501 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 06, Chapter 05 – Bulletin Vol. 25-5

18.06.06, Surplus Lines Rules

18-0606-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
18-0606-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 06, Chapter 06 – Bulletin Vol. 24-7

18.07.04, Annual Financial Reporting

18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 07, Chapter 04 – Bulletin Vol. 24-7

18.07.05, Director's Authority for Companies Deemed to be in Hazardous Financial Condition

18-ZBRR-2401 ***Rules of the Idaho Department of Insurance*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 07, Chapter 05 – Bulletin Vol. 24-7

18.08.01, Adoption of the International Fire Code

18-0801-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
18-0801-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-9
18-0801-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

IDAPA 20 – DEPARTMENT OF LANDS

20.01.01, Rules of Practice and Procedure Before the State Board of Land Commissioners

44-0000-2400 *Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA 20.01.01 – Bulletin Vol. 24-7*

20.03.02, Rules Governing Mined Land Reclamation

20-0302-2401 (2nd) Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4
20-0302-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

20.03.04, Rules for the Regulation of Beds, Waters, and Airspace Over Navigable Lakes in the State of Idaho

20-0304-2401 (2nd) Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4
20-0304-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

20.03.08, Easements on State Owned Lands

20-0308-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-3

20.03.13, Administration of Cottage Site Leases on State Lands

20-0313-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
20-0313-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
20-0313-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-3

20.03.14, Rules Governing Grazing, Farming, and Conservation Leases

20-0314-2401* Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
**Changes chapter name from: "Rules Governing Grazing, Farming, Conservation, Noncommercial Recreation, and Communication Site Leases"*
20-0314-2401* Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7

20-0314-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-3

20.03.15, Rules Governing Geothermal Leasing on Idaho State Lands

20-0315-2401 Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-10 (PLR 2025)
20-0315-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-7
20-0315-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-3

20.03.16, Rules Governing Oil and Gas Leasing on Idaho State Lands

20-0316-2401 Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-10 (PLR 2025)
20-0316-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-7
20-0316-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-3

20.04.01, Rules Pertaining to Forest Fire Protection

20-0401-2301 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
20-0401-2301 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
20-0401-2301 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 23-10

20.04.02, Rules Pertaining to the Idaho Forestry Act and Fire Hazard Reduction Laws

20-0402-2301 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
20-0402-2301 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
20-0402-2301 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 23-10

20.07.02, Rules Governing Conservation of Oil and Natural Gas in the State of Idaho

20-0702-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
20-0702-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-8
20-0702-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

IDAPA 21 – DIVISION OF VETERANS SERVICES

21.01.01, Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure

21-0101-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

44-0000-2400 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA 21.01.01 – Bulletin Vol. 24-7

21.01.04, Rules Governing Idaho State Veterans Cemeteries

21-0104-2402 Adoption of Pending Rule (Fee Rule), Bulletin Vol. 25-1 (PLR 2025)
21-0104-2402 Notice of Proposed Rulemaking (Fee Rule), Bulletin Vol. 24-6

21-0104-2401 Adoption of Temporary Rule (Fee Rule), Bulletin Vol. 24-5 (eff. 4-10-24)T

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapter 01; Title 03, Chapter 01; Title 08, Chapter 01; Title 09, Chapter 01; Title 19, Chapter 01; Title 24, Chapter 01; Title 29, Chapter 01; Title 33, Chapters 01-07; and Title 36, Chapter 01 – Bulletin Vol. 24-4

24.02.01, Rules of the State Athletic Commission

24-0201-2402 Adoption of Pending Rule (ZBR New Chapter, Fee Rule), Bulletin Vol. 24-11 (PLR 2025)
24-0201-2402 Notice of Proposed Rulemaking (ZBR New Chapter), Bulletin Vol. 24-8
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapter 01 – Bulletin Vol. 24-4

24-0201-2401 Adoption of Temporary Rule (New Chapter, Fee Rule), Bulletin Vol. 24-6 (eff. 6-1-24)T

24.03.01, Rules of the State Board of Chiropractic Physicians

24-0301-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-0301-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7

24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 01 – Bulletin Vol. 24-4

24.04.01, Rules of the Board of Registration for Professionals Geologists

24-0401-2401 Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-12 (PLR 2025)
24-0401-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-10
24-0401-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-6

24.06.01, Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants

24-0601-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-5

24.08.01, Rules of the State Board of Morticians

24-0801-2401 Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-11 (PLR 2025)
24-0801-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-9
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 08, Chapter 01 – Bulletin Vol. 24-4

24.09.01, Rules of the Board of Examiners of Nursing Home Administrators

24-0901-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-0901-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 09, Chapter 01 – Bulletin Vol. 24-4

24.13.01, Rules Governing the Physical Therapy Licensure Board

24-1301-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-5

24.17.01, Rules of the State Board of Acupuncture

24-1701-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-5

24.19.01, Rules of the Board of Examiners of Residential Care Facility Administrators

24-1901-2401 Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-10 (PLR 2025)
24-1901-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 19, Chapter 01 – Bulletin Vol. 24-4

24.21.01, Rules of the Idaho State Contractors Board

24-2101-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-5

24-2101-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
24-2101-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
24-2101-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-6

24.22.01, Rules of the Idaho State Liquefied Petroleum Gas Safety Board

24-2201-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-5

24-2201-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
24-2201-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
24-2201-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

24.24.01, Rules of the Genetic Counselors Licensing Board

24-2401-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-2401-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 24, Chapter 01 – Bulletin Vol. 24-4

24.26.01, Rules of the Idaho Board of Midwifery

24-2601-2501 Adoption of Temporary Rule, Bulletin Vol. 25-1 (eff. 1-1-25)T

24.28.01, Rules of the Barber and Cosmetology Services Licensing Board

24-2801-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-5

24.29.01, Rules of Procedure of the Idaho Certified Shorthand Reporters Board

24-2901-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
24-2901-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-8
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 29, Chapter 01 – Bulletin Vol. 24-4

24.30.01, Idaho Accountancy Rules

24-3001-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
24-3001-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-9
24-3001-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-6

24.31.01, Rules of the Idaho State Board of Dentistry

24-3101-2501 Adoption of Temporary Rule, Bulletin Vol. 25-1 (eff. 1-1-25)T

24.32.01, Rules of the Idaho Board of Licensure of Professional Engineers and Professional Land Surveyors

24-3201-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
24-3201-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
24-3201-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-6

24.33.01, Rules of the Board of Medicine for the Practice of Medicine and Osteopathic Medicine in Idaho

24-3301-2401* Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-10 (PLR 2025)
**Changes chapter name from: "Rules of the Board of Medicine for the Licensure to Practice Medicine and Osteopathic Medicine in Idaho"*
24-3301-2401* Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 33, Chapter 01 – Bulletin Vol. 24-4

24.33.02, Rules for the Licensure of Physician Assistants

24-3302-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-3302-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 33, Chapter 02 – Bulletin Vol. 24-4

24.33.03, General Provisions of the Board of Medicine

24-3303-2401 Adoption of Pending Rule (ZBR Chapter Repeal), Bulletin Vol. 24-10 (PLR 2025)
24-3303-2401 Notice of Proposed Rulemaking (ZBR Chapter Repeal), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 33, Chapter 03 – Bulletin Vol. 24-4

24.33.04, Rules for the Licensure of Naturopathic Medical Doctors

24-3304-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-3304-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 33, Chapter 04 – Bulletin Vol. 24-4

24.33.05, Rules for the Licensure of Athletic Trainers to Practice in Idaho

24-3305-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-3305-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 33, Chapter 05 – Bulletin Vol. 24-4

24.33.06, Rules for Licensure of Respiratory Therapists and Permitting of Polysomnographers in Idaho

24-3306-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-3306-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 33, Chapter 06 – Bulletin Vol. 24-4

24.33.07, Rules for the Licensure of Dietitians

24-3307-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-10 (PLR 2025)
24-3307-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-7
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 33, Chapter 07 – Bulletin Vol. 24-4

24.34.01, Rules of the Idaho Board of Nursing

24-3401-2501 Adoption of Temporary Rule, Bulletin Vol. 25-1 (eff. 1-1-25)T

24.35.01, Rules of the Outfitters and Guides Licensing Board

24-3501-2401 Adoption of Pending Rule, Bulletin Vol. 24-11 (PLR 2025)
24-3501-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-8
24-3501-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-6

24.36.01, Rules of the Idaho State Board of Pharmacy

24-3601-2402 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
24-3601-2402 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-8
24-ZBRR-2401 ***Rules of the Division of Occupational and Professional Licenses*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 36, Chapter 01 – Bulletin Vol. 24-4

24-3601-2401 Adoption of Temporary Rule, Bulletin Vol. 24-4 (eff. 7-1-24)T

24.37.01, Rules of the Idaho Real Estate Commission

24-3701-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
24-3701-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
24-3701-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-6

24.38.01, Rules of the State of Idaho Board of Veterinary Medicine

24-3801-2501 Adoption of Temporary Rule, Bulletin Vol. 25-1 (eff. 1-1-25)T

24.39.10, Rules of the Idaho Electrical Board

24-3910-2402 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
24-3910-2402 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
24-3910-2402 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

24-3910-2401 Adoption of Temporary Rule, Bulletin Vol. 24-5 (eff. 4-19-24)T

24.39.30, Rules of Building Safety (Building Code Rules)

24-3930-2501 Adoption of Temporary Rule, Bulletin Vol. 25-1 (eff. 1-1-25)T

24.39.31, Rules for Factory Built Structures

24-3931-2501 Adoption of Temporary Rule, Bulletin Vol. 25-1 (eff. 1-1-25)T

24.39.40, Safety Rules for Elevators, Escalators, and Moving Walks

24-3940-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
24-3940-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-11
24-3940-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

24.39.50, Rules of the Public Works Contractors License Board

24-3950-2501 Adoption of Temporary Rule, Bulletin Vol. 25-1 (eff. 1-1-25)T

24.39.60, Rules Governing Uniform School Building Safety

24-3960-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
24-3960-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-11
24-3960-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

24.39.70, Rules Governing Installation of Heating, Ventilation, and Air Conditioning Systems

24-3970-2401 Adoption of Temporary Rule, Bulletin Vol. 24-8 (eff. 7-10-24)T ***[expires sine die 2025]***

24.39.80, Idaho Minimum Safety Standards and Practices for Logging

24-3980-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
24-3980-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-11
24-3980-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-7

24.39.90, Rules Governing the Damage Prevention Board

24-3990-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-11 (PLR 2025)
24-3990-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-8

24-3990-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-6

IDAPA 26 – DEPARTMENT OF PARKS AND RECREATION

26.01.20, Rules Governing the Administration of Park and Recreation Areas and Facilities

26-0120-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

26.01.21, Rules Governing Leasing Practices & Procedures for Recreational Residences Within Heyburn State Park

26-0121-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

26.01.37, Rules Governing Test Procedures and Instruments for Noise Abatement of Off Highway Vehicles

26-0137-2401 Adoption of Pending Rule (ZBR Chapter Repeal), Bulletin Vol. 25-1 (PLR 2025)
26-0137-2401 Notice of Proposed Rulemaking (ZBR Chapter Repeal), Bulletin Vol. 24-10
26-0137-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8

IDAPA 31 – PUBLIC UTILITIES COMMISSION

31.21.01, Customer Relations Rules for Gas, Electric & Water Public Utilities (The Utility Customer Relations Rules)

31-2101-2401 Adoption of Pending Rule, Bulletin Vol. 24-10 (PLR 2025)
31-2101-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-8

31.41.01, Customer Relations Rules for Telephone Corporations Providing Services in Idaho Subject to Customer Service Regulation by the Idaho Public Utilities Commission

31-4101-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
31-4101-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
31-4101-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8

IDAPA 34 – SECRETARY OF STATE

34.03.01, Rules Implementing the Sunshine Law

34-0301-2501 Notice of Proposed Rulemaking, Bulletin Vol. 25-6

34.08.01, Rules Governing Paid Signature Gatherers

34-0801-2401 Adoption of Pending Rule (New Chapter), Bulletin Vol. 24-12 (PLR 2025)
34-0801-2401 Notice of Temporary and Proposed Rule (New Chapter), Bulletin Vol. 24-9 (eff. 7-1-24)T

IDAPA 35 – STATE TAX COMMISSION

35.01.02, Idaho Sales and Use Tax Administrative Rules

35-0102-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

35.01.03, Property Tax Administrative Rules

35-0103-2402 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
35-0103-2402 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-9 (eff. 7-30-24)T

35-0103-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
35-0103-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-9
35-0103-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7

35.01.05, Idaho Motor Fuels Tax Administrative Rules

35-0105-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
35-0105-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
35-0105-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

35.01.06, Hotel/Motel Room and Campground Sales Tax Administrative Rules

35-0106-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

35.01.10, Idaho Cigarette and Tobacco Products Tax Administrative Rules

35-0110-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)

35-0110-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
35-0110-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

35.02.01, Tax Commission Administration and Enforcement Rules

35-0201-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-7 (rulemaking terminated by agency)

IDAPA 37 – DEPARTMENT OF WATER RESOURCES

37.02.04, Shoshone-Bannock Tribal Water Supply Bank Rules

37-0204-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

37.03.01, Adjudication Rules

37-0301-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
37-0301-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
37-0301-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

37.03.02, Beneficial Use Examination Rules

37-0302-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
37-0302-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
37-0302-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

37.03.03, Rules and Minimum Standards for the Construction and Use of Injection Wells

37-0303-2301 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
37-0303-2301 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
37-0303-2301 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 23-4

37.03.07, Stream Channel Alteration Rules

37-0307-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

37.03.09, Well Construction Standards Rules

37-0309-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
37-0309-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
37-0309-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

37.03.11, Rules for Conjunctive Management of Surface and Ground Water Resources

37-0311-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
37-0311-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10

37.03.12, Idaho Department of Water Resources Water Distribution Rules - Water District 34

37-0312-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

IDAPA 38 – IDAHO DEPARTMENT OF ADMINISTRATION

38.04.04, Rules Governing Capitol Mall Parking

38-0404-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

38.05.01, Rules of the Division of Purchasing

38-0501-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)
38-0501-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-11
38-0501-2401 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 24-10

44-0000-2400 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA chapter 38.05.01– Bulletin Vol. 24-7

IDAPA 39 – IDAHO TRANSPORTATION DEPARTMENT

39-ZBRR-2501 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapter 60; and Title 03, Chapter 49 – Bulletin Vol. 25-5

39-ZBRR-2402 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapters 41, 60, 65 – Bulletin Vol. 24-7

39-ZBRR-2401 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapters 03, 72, 75 – Bulletin Vol. 24-5

39.02.03, Rules Governing Vehicle Dealer's Principle Place of Business and Claims to the Idaho Consumer Asset Recovery Fund

39-0203-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
39-0203-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
39-ZBRR-2401 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapter 03 – Bulletin Vol. 24-5

39.02.60, Rules Governing License Plate Provisions

39-ZBRR-2501 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapter 60 – Bulletin Vol. 25-5

39.02.72, Rules Governing Administrative License Suspensions

44-0000-2400 *Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA chapter 39.02.72 – Bulletin Vol. 24-7*

39-ZBRR-2401 ***Rules of the Idaho Transportation Department*** *– Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapter 72 – Bulletin Vol. 24-5 (rulemaking terminated)*

39.02.75, Rules Governing Names on Driver's Licenses and Identification Cards

39-0275-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
39-0275-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
39-ZBRR-2401 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 02, Chapter 75 – Bulletin Vol. 24-5

39.03.41, Rules Governing Traffic Control Devices

39-0341-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
39-0341-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10
39-ZBRR-2402 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 41 – Bulletin Vol. 24-7

39.03.49, Rules Governing Ignition Interlock Breath Alcohol Devices

39-ZBRR-2501 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 49 – Bulletin Vol. 25-5

39.03.60, Rules Governing Outdoor Advertising, Accident Memorials, and Other Official Signs

39-0360-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
39-0360-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
39-ZBRR-2402 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 60 – Bulletin Vol. 24-7

39.03.65, Rules Governing Traffic Minute Entries

39-0365-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
39-0365-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
39-ZBRR-2402 ***Rules of the Idaho Transportation Department*** – Omnibus Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking – Negotiates Title 03, Chapter 65 – Bulletin Vol. 24-7

IDAPA 42 – IDAHO WHEAT COMMISSION

42.01.01, Rules of the Idaho Wheat Commission

42-0101-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8

IDAPA 43 – IDAHO OILSEED COMMISSION

43.01.01, Rules Governing the Idaho Oilseed Commission

43-0101-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 25-1 (PLR 2025)

43-0101-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-10
43-0101-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-8

IDAPA 44 – OFFICE OF THE ADMINISTRATIVE RULES COORDINATOR

44-0000-2401 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA 15.04.01 – Bulletin Vol. 24-8

44-0000-2400 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA chapters 04.11.01, 11.04.01, 16.05.03, 20.01.01, 21.01.01, 38.05.01, 39.02.04, 39.02.72, 52.01.03, and 59.01.01 – Bulletin Vol. 24-7

IDAPA 45 – HUMAN RIGHTS COMMISSION

45.01.01, Rules of the Idaho Human Rights Commission

45-0101-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-6

IDAPA 47 – DIVISION OF VOCATIONAL REHABILITATION

47.01.01, Rules Governing Vocational Rehabilitation Services

47-0101-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
47-0101-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-10

IDAPA 50 – COMMISSION OF PARDONS AND PAROLE

50.01.01, Rules of the Commission of Pardons and Parole

50-0101-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
50-0101-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-10 (eff. 7-1-24)T

IDAPA 52 – IDAHO STATE LOTTERY COMMISSION

52.01.03, Rules Governing Operations of the Idaho State Lottery

52-0103-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-5

44-0000-2400 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA chapter 52.01.03 – Bulletin Vol. 24-7

52-0103-2401 Adoption of Pending Rule, Bulletin Vol. 25-1 (PLR 2025)
52-0103-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-6 (eff. 7-1-24)T

IDAPA 55 – DIVISION OF CAREER TECHNICAL EDUCATION

55.01.03, Rules of Career Technical Centers

55-0103-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-6

IDAPA 57 – SEXUAL OFFENDER MANAGEMENT BOARD

57.01.01, Rules of the Sexual Offender Management Board

57-0101-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

57-0101-2502 Adoption of Temporary Rule, Bulletin Vol. 25-4 (eff. 2-14-25)T

IDAPA 58 – DEPARTMENT OF ENVIRONMENTAL QUALITY

TMDLs:
58-0000-2501 Notice of Final Decision, Willow Creek 2024 Total Maximum Daily Loads (TMDLs) (HUC 17040205), Bulletin Vol. 25-4

58.01.01, Rules for the Control of Air Pollution in Idaho

58-0101-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
58-0101-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-9

58.01.02, Water Quality Standards

58-0102-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
58-0102-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-8

58.01.03, Individual/Subsurface Sewage Disposal Rules and Rules for Cleaning of Septic Tanks

58-0103-2301 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
58-0103-2301 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-6
58-0103-2301 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 23-9

58.01.05, Rules and Standards for Hazardous Waste

58-0105-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
58-0105-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-8

58.01.06, Solid Waste Management Rules

58-0106-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-3

58.01.08, Idaho Rules for Public Drinking Water Systems

58-0108-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
58-0108-2401 Notice of Proposed Rulemaking, Bulletin Vol. 24-9

58.01.10, Rules Regulating the Disposal of Radioactive Materials Not Regulated Under the Atomic Energy Act of 1954, As Amended

58-0110-2301 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
58-0110-2301 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-8
58-0110-2301 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 23-9

58.01.11, Ground Water Quality Rule

58-0111-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-3

58.01.12, Rules for Administration of Wastewater and Drinking Water Loan Funds

58-0112-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-4

58.01.13, Rules for Ore Processing by Cyanidation

58-0113-2500 Notice of Revocation of Final Rule, Bulletin Vol. 25-5

58.01.14, Rules Governing Fees for Environmental Operating Permits, Licenses, and Inspection Services

58-0114-2401 Adoption of Pending Rule (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-12 (PLR 2025)
58-0114-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite, Fee Rule), Bulletin Vol. 24-9
58-0114-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

58.01.16, Wastewater Rules

58-0116-2501 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 25-3

58.01.22, Rules for Administration of Planning Grants for Drinking Water and Wastewater Facilities

58-0122-2401 Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
58-0122-2401 Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-9
58-0122-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-4

58.01.23, Contested Case Rules and Rules for Protection and Disclosure of Records

58-0123-2401 Adoption of Pending Rule, Bulletin Vol. 24-12 (PLR 2025)
58-0123-2401 Notice of Temporary and Proposed Rule, Bulletin Vol. 24-7 (eff. 7-1-24)T

58.01.24, Standards and Procedures for Application of Risk Based Corrective Action at Petroleum Release Sites

58-0124-2401* Adoption of Pending Rule (ZBR Chapter Rewrite), Bulletin Vol. 24-12 (PLR 2025)
**Changes chapter name from: "Standards and Procedures for Application of Risk Based Corrective Action at Petroleum Release Sites"*
58-0124-2401* Notice of Proposed Rulemaking (ZBR Chapter Rewrite), Bulletin Vol. 24-8
58-0124-2401 Notice of Intent to Promulgate Rules – Zero-Based Regulation (ZBR) Negotiated Rulemaking, Bulletin Vol. 24-3

IDAPA 59 – PUBLIC EMPLOYEE RETIREMENT SYSTEM OF IDAHO (PERSI)

59.01.01, Rules for the Public Employee Retirement System of Idaho (PERSI)

44-0000-2400 Notice of Omnibus Rulemaking – Revocation of Final Rule – Certain provisions rendered null and void pertaining to IDAPA chapter 59.01.01 – Bulletin Vol. 24-7

IDAPA 61 – STATE PUBLIC DEFENSE COMMISSION

61-0000-2400 ***Rules of the Idaho State Public Defense Commission*** *– Notice of Omnibus Rulemaking – Adoption of Temporary Rule – Reauthorizes Title 01, Chapters 01-04 – Bulletin Vol. 24-4 (eff.* ***sine die*** *2024)T* ***[temporary rule expires 10-1-24]***

61.01.01, ***[Rule Expired]*** *General Provisions and Definitions*

61-0000-2400 ***Rules of the Idaho State Public Defense Commission*** *– Notice of Omnibus Rulemaking – Adoption of Temporary Rule – Reauthorizes Title 01, Chapter 01 – Bulletin Vol. 24-4 (eff.* ***sine die*** *2024)T* ***[temporary rule expires 10-1-24]***

61.01.02, ***[Rule Expired]*** *Requirements and Procedures for Representing Indigent Persons*

61-0000-2400 ***Rules of the Idaho State Public Defense Commission*** *– Notice of Omnibus Rulemaking – Adoption of Temporary Rule – Reauthorizes Title 01, Chapter 02 – Bulletin Vol. 24-4 (eff.* ***sine die*** *2024)T* ***[temporary rule expires 10-1-24]***

61.01.03, ***[Rule Expired]*** *Records, Reporting, and Review*

61-0000-2400 ***Rules of the Idaho State Public Defense Commission*** *– Notice of Omnibus Rulemaking – Adoption of Temporary Rule – Reauthorizes Title 01, Chapter 03 – Bulletin Vol. 24-4 (eff.* ***sine die*** *2024)T* ***[temporary rule expires 10-1-24]***

61.01.04, ***[Rule Expired]*** *Financial Assistance and Training Resources*

61-0000-2400 ***Rules of the Idaho State Public Defense Commission*** *– Notice of Omnibus Rulemaking – Adoption of Temporary Rule – Reauthorizes Title 01, Chapter 04 – Bulletin Vol. 24-4 (eff.* ***sine die*** *2024)T* ***[temporary rule expires 10-1-24]***

IDAPA 62 – OFFICE OF ADMINISTRATIVE HEARINGS

62.01.01, Idaho Rules of Administrative Procedure

62-0101-2501 Notice of Intent to Promulgate Rules – Negotiated Rulemaking, Bulletin Vol. 25-6

IDAPA 63 – IDAHO COUNCIL ON DOMESTIC VIOLENCE AND VICTIM ASSISTANCE

63.05.04, Domestic Violence Council Grants

****(Re-designated from IDAPA 16.05.04 to 63.05.04)***

63-0504-2400 **IDAPA 63 – IDAHO COUNCIL ON DOMESTIC VIOLENCE AND VICTIM ASSISTANCE** – Notice of Assignment of New IDAPA Designation Number – Redesignated to ***IDAPA 63, Title 05, Chapter 04*** from ***IDAPA 16, Title 05, Chapter 04*** – Bulletin Vol. 24-6 (eff. 7-1-24)

Subject Index

Numerics

2026 NR Draw Hunts For Elk & Deer 32
- Application Eligibility 32
- Application Period 33
- Deadline for Claiming Tags & Sale of Unclaimed Tags 33
- Definitions 32
- Discounted Application Fee 33
- Eligibility for Multiple Hunt Applications & Tag Limits 32
- Group Application 33
- Hunt Choices 33
- Refunds 33

A

A&D Waiver Services
- Coverage & Limitations 285
- A&D Case Management 288
- Adult Day Health 285
- Adult Residential Care 285
- Attendant Care 286
- Chore Services 286
- Companion Services 286
- Consultation (Self-Direction) 287
- Day Habilitation 288
- Environmental Accessibility Adaptations 287
- Home-Delivered Meals 287
- Homemaker Services 287
- Non-Medical Transportation (NMT) 286
- Personal Emergency Response System (PERS) 287
- Residential Habilitation 287
- Respite Care 287
- Skilled Nursing 287
- Specialized Medical Equipment & Supplies 286
- Supported Employment 288
- Transition Services 288
- Definitions 285
- A&D Waiver Services 285
- Employer of Fact 285
- Employer of Record 285
- Eligibility 285
- Admission to a NF 285
- Age 285
- Average Daily Cost 285
- Disabling Condition 285
- NF Level of Care, Adults 285
- Non-Institutional Setting 285
- Non-Use 285
- Require Services 285
- Procedural Requirements 288
- Individual Service Plan 288
- Provider Notification 289
- Provider Records 289
- Provider Qualifications & Duties 289
- A&D Case Management 291
- Adult Day Health 290
- Adult Residential Care 290
- Attendant Care 291
- Chore Services 291
- Consultation Services 290
- Day Habilitation 291
- Electronic Visit Verification (EVV) Compliance 291
- Employment Status 289
- Environmental Accessibility Adaptations 291
- Fiscal Intermediary Services (FI) 289
- Home-Delivered Meals 290
- Homemaker Services 291
- Non-Medical Transportation 291
- PERS 290
- Provider Qualifications 290
- Quality Assurance (QA) 290
- Rates 291
- Residential Habilitation 291
- Respite Care 291
- Specialized Medical Equipment & Supplies 290
- Supported Employment 291
- Transition Services 291
- Provider Reimbursement 291

Abortion For Minors 348

Abuse, Neglect Or Domestic Violence 349

Abuse, Neglect, Or Domestic Violence 345
- Incapacity of Victim 345
- Judgment of Professional Staff 345

Access To An Individual's Own Record 346
- Children's Mental Health 346
- Clinical Laboratories 347
- Confidential Information 347
- Legal Action 347

Access To Medical Records 42

Accessibility for Persons with Mobility & Sensory Requirements For Building Construction & Physical Standards
- Impairments 148

Accounting Treatment 203
- Final Payment 203
- Overpayments 203

Acquired Immune Deficiency Syndrome (AIDS) 58
- Investigation 58
- Reporting Requirements 58

Activity Requirements 139
- Community Resources for Activities 139
- Education 139
- Physical Activities 139
- Socialization 139

Additional Fire & Life Safety Standards For All Buildings & Facilities 161

Additional Fire And Life Safety Standards For All Buildings And Facilities
- Electrical Installations & Equipment 161
- Fuel-Fired Heating 162
- Medical Gases 162
- Natural or Man-Made Hazards 162
- Prohibited Applications 162
- Telephone 162

Additional Training Related To Changes 169

Administrative Appeals & Contested Cases 128

Admission Requirements 139
- Acceptable Admissions 140
- Admissions Policies 139
- Resident Admission, Discharge, & Transfer 140

Adoption 349

Adult DD HCBS State Plan Option 307
- Eligibility 307

Adult DD HCBS Waiver Services 312

Adult DD Services
- Coverage & Limitations 300
- Definitions 299
- Clinical Review 299
- Exception Review 299
- Health 299
- Health Risks 299
- Safety 300
- Safety Risks 300
- Eligibility Determination 300
- Procedural Requirements 300
- Provider Reimbursement 302
- Exception Review 303
- Individualized Budget 302
- Supported Living Levels of Support 303
- Service Plan Requirements 300
- Addendum to the Service Plan 302
- Annual Service Reauthorization 302
- Assessment 300
- Informed Choice 301
- No Duplication of Services 301
- Notifications 302
- Paid Plan Developer Qualifications 301
- Plan Development 301
- Plan Monitoring 301
- Provider Implementation Plan (PIP) 301
- Provider Status Reviews 301

Adult DD Waiver Services 312
- Coverage & Limitations 313
- Adult Day Health 314
- Behavior Consultation/Crisis Management 314
- Chore Services 313
- Environmental Accessibility Adaptations 314
- Home Delivered Meals 314
- Limitations 315
- Non-Medical Transportation

(NMT) 314
Personal Emergency Response System (PERS) 314
Residential Habilitation 313
Respite Care 313
Self-Directed Community Supports 314
Skilled Nursing 314
Specialized Medical Equipment & Supplies 314
Supported Employment 313
Transition Services 314
Participant Eligibility 312
Adult DD Waiver Limits 313
Age 312
DD Waiver Eligibility 312
Eligibility 312
Notifications 312
Redetermination 312
Procedural Requirements 315
Documentation Required 315
Provider Notification 315
Service Authorization 315
Provider Qualifications & Duties 316
Adult Day Health 317
Behavior Consultation or Crisis Management 317
Chore Services 316
Home-Delivered Meals 316
Non-Medical Transportation 316
PERS 316
Residential Habilitation – CFH 316
Residential Habilitation – Supported Living 316
Respite Care 316
Specialized Medical Equipment 316
Supported Employment 316
Transition Services 317
Provider Reimbursement 317
Aged And Disabled (A&D) Waiver Services 284
Agencies Approved Through National Accreditation
Facility Standards For Agencies Providing Center-Based Services 110
General Training Requirements 110
Agency Record Requirements
Administrative Records 111
Agency Reporting Policy
Incident Reports 116
Ambulatory Surgical Center Services
Coverage & Limitations 214
Provider Qualifications & Duties 214
Provider Reimbursement 214
Ambulatory Surgical Centers 214
Amebiasis & Free-Living Amebae 59
Investigation 59
Reporting Requirements 59
Restrictions - Daycare Facility 59
Restrictions - Food Service Facility 59
Restrictions - Health Care Facility 59
Restrictions - Household Contacts 59
Amendment Of Record 347
Amendment of Health Information 347
Updating Identifying Information 347
Anthrax 59
Handling of Report 60
Investigation 59
Reporting Requirements 59
Appeal Of Lock-In 335
Application & Examinations 97
Application For Initial Certification 105
Certificate 108
Certification Required 105
Content Of Application For Certification 106
Denial of an Application 108
Department Review Not Guaranteed 105
Notification To the Department 108
Open Application 106
Survey and Investigations 108
Application For License 92
Application For License 92
Emergency Action 95
Minimum Safety Requirements 93
Modification, Revocation, and Termination of Licensees 94
Operator Qualifications 93
Qualifications for Authorized Operation, Service, & Repair of X-ray Machines 92
Responsible Authority 92
Subjects to Be Covered During the Instruction of Radiographers 94
Arboviral Diseases 60
Investigation 60
Reporting Requirements 60
Assistance With Medications 169
Delegation 169
Training Requirements 169
Audiology Services 239
Coverage & Limitations 239
Binaural Hearing Aids 239
Implantable Hearing Aids 239
Non-Implantable Hearing Aids 239
Procedural Requirements 239
Additional Testing 239
Provider Documentation Requirements 239
Waiver of Impedance Test 240
Warranties 240
Authorization For The Use & Disclosure Of Health & Other Confidential Information 342
Authorization for the Use & Disclosure of Health Information 342
Content of Authorization 342
Copy of Authorization 342
Defective Authorization 342
Effect on Benefits & Services 342
Psychotherapy Notes 342
Revocation of an Authorization 342
Availability Of Certificate 110

B

Background Check Requirements 177
Background Check Compliance 177
Department-Issued Variances 177
Providers Subject to Background Check Requirements 177
Subsequent Convictions, Charges, or Investigations 177
Behavioral Health Services 234
Coverage & Limitations 234
Participant Eligibility 234
Procedural Requirements 234
Authorization 234
Complaints, Grievances, & Appeals 234
Enrollment 234
Provider Qualifications & Duties 234
All Services 234
Inpatient Services 234
Provider Reimbursement 235
Biotinidase Deficiency 60
Botulism 60
Handling of Report 60
Investigation 60
Reporting Requirements 60
Brucellosis 60
Handling of Report 60
Investigation 60
Reporting Requirements 60

C

Campylobacteriosis 60
Investigation 61
Reporting Requirements 61
Restrictions - Day Care Facility 61
Restrictions - Food Service Facility 61
Restrictions - Health Care Facility 61
Cancer 61
Cancers Designated as Reportable 61
Handling of Report 61
Report Content 61
Reported By Whom 61

Reporting Requirements 61
Case Management 214
Community Re-entry Services 214
Coverage & Limitations 215
Community Re-entry Services 215
Home Visiting Coverage 215
Home Visiting Services 214
Participant Eligibility 214
Community Re-entry Services 215
Home Visiting Services 214
Provider Qualifications & Duties 215
Case Management Services 214
Certificate Not Transferable 110
Certification Identification (ID) Card 97
Certification Requirements for DDA, Residential Habilitation Agencies, and Adult Residential Care Facilities 105
Application for Initial Certification 106
Certification Requirements for Developmental Disabilities Agencies 105
Chancroid 62
Investigation & Notification of Contacts 62
Reporting Requirements 62
Change Of Ownership 137
Application for Change of Ownership 137
Change of Ownership for a Facility In Litigation 137
Non-Transfer of Facility License 137
Changes That Require Reporting 109
Center-Based Services 109
New Ownership 109
Notification To The Department 109
Updated Certificate Necessary 109
Child Protection 349
Child Fatalities 349
Public Disclosure 349
Children's DD HCBS State Plan Option Procedural Requirements 306
Children's DD HCBS State Plan Option 303
Coverage & Limitations 304
Community-Based Supports 305
Family Education 305
Family-Directed Community Supports (FDCS) 305
Limitations for State Plan & Family-Directed Community Supports (FDCS) 305
Respite 304
Definitions 304
Community 304
Family-Centered Planning Process 304
Family-Centered Planning Team 304
Eligibility Determination 304
Annual Re-Evaluation 304
Individualized Budget Methodology 304
Lapse in Service 304
Procedural Requirements
Documentation 306
Quality Assurance 306
Supervision 306
Provider Qualifications & Duties 306
Community-Based Support 307
Family Education 307
Respite 306
Reimbursement 307
Service Plan 305
Addendums 306
Annual Reauthorization for State Plan & Family-Directed Community Supports (FDCS) 306
History & Physical 305
Plan Monitoring 306
Provider Status Reviews 306
Requirements for Collaboration 306
Service Plan Development 306
Children's Mental Health 349
Chiropractic Services
Coverage & Limitations 217
Definitions 217
CHIS 219
Coverage And Limitations 220
Required Order 220
Required Screening 220
Service Delivery 220
Services 220
Definitions 219
Assessment & Clinical Treatment Plan (ACTP) 219
Aversive Intervention 219
Community 219
Developmental Disabilities Agency (DDA) 219
Duplicate Services 219
Fidelity 219
Eligibility Requirements 219
Procedural Requirements 221
Documentation 222
Implementation Plan(s) 222
Prior Authorization (PA) Request 221
Supervision 222
Provider Qualifications And Duties 222
Continuing Training Requirements 223
Crisis Intervention Technician 222
Evidence-Based Model (EBM) Intervention Paraprofessional 223
Evidence-Based Model (EBM) Intervention Professional 223
Evidence-Based Model (EBM) Intervention Specialist 223
Independent CHIS Provider 223
Intervention Professional 223
Intervention Specialist 222
Intervention Specialists 224
Intervention Technician 222
Provider Reimbursement 224
Quality Assurance 224
Quality Assurance 224
Quality Improvement 224
Chlamydia Trachomatis 62
Investigation 62
Prophylaxis of Newborns 62
Reporting Requirements 62
Restrictions - Health Care Facility 62
Choice Of Providers 184
Cholera 62
Handling of Report 62
Investigation 62
Reporting Requirements 62
Restrictions - Day Care Facility 62
Restrictions - Food Service Facility 62
Restrictions - Health Care Facility 62
Restrictions - Household Contacts 63
Communications 96
Community Crisis Supports 307
Coverage & Limitations 307
Before Plan Development 307
Crisis Resolution Plan 308
Emergency Room (ER) 307
Comprehensive Assessment Requirements 154
Assessment Results 155
Level of Personal Assistance Required 155
Maladaptive Behaviors 155
Nursing Assessment 155
Outside Services 155
Resident Demographics 154
Resident Preferences 155
Conditions For Payment 186
Acceptance of State Payment 186
Comply With All Applicable Regulations 186
Comply With the Idaho Medicaid Provider Handbook 186
Follow-up Communication 187
Medical Care Provided Outside the State of Idaho 186
Ordering, Referring, & Prescribing Providers (ORP) 187
Participant Eligibility 186
Prior Authorization (PA) 187
Referrals 187
Conducting Industrial Radiographic

Operations 97
Congenital Hypothyroidism 63
Consent To Gather, Use & Disclose Information 341
Continuing Training Requirements 169
Criminal 110
Criminal History & Background Check Requirements 103, 129
Availability to Work 129
Criminal History & Background Check 129
Employer Discretion 130
New Criminal History & Background Check 129
Scope of a Criminal History & Background Check 129
Submission of Fingerprints 129
Use of Previous Criminal History & Background Check 130
Verification of Compliance 103
Criminal History And Background Check Requirements
Reporting Criminal Convictions, Pending Investigations, Or Pending Charges 103
Criteria For Lock-In 334
Controlled Substances 334
Demonstrated Abusive Patterns 334
Drug Abuse 334
Drug-Seeking Behavior 334
Multiple Providers 334
Other Abusive Utilization 334
Overlapping Prescription Drugs With the Same Therapeutic Classes 334
Unnecessary Use of Providers or Services, Including Excessive Provider Visits 334
Use of Emergency Room 334
Use of Multiple Prescribing Providers or Pharmacies 334
Cryptosporidiosis 63
Investigation 63
Reporting Requirements 63
Restrictions - Day Care Facility 63
Restrictions - Food Service Facility 63
Restrictions - Health Care Facility 63

D

Data For Research Or Other Purposes 348
Daycare Facility - Reporting & Control Measures 52
Prevention of the Transmission of Disease 53
Readily Transmissible Diseases 52
Restrictable Disease - Attendance 53
Restrictable Disease - Work 52
DD Determination Standards
Participant Eligibility 296
Impairment 297
Necessity of Care 298
Substantial Functional Limitations 297
Test Instruments 299
Assessments 299
Children's Test Instruments 299
DD Services
Administrative Appeals 299
Quality Improvement 299
Abuse, Fraud, or Substandard Care 299
Corrective Action 299
Quality Improvement (QI) 299
Requirements 296
Right Care 296
Right Outcomes 296
Right Place 296
Right Price 296
DDA Services 105
Definitions 95, 97
A Through H 178
Activities of Daily Living (ADL) 178
Adult Day Health (ADH) 178
Agency 178
Amortization 178
Audit 178
Budget Adjustment Factor (BAF) 178
Case Mix Adjustment Factor 178
Case Mix Index (CMI) 178
Children's Habilitation Intervention Services (CHIS) 179
Children's Health Insurance Program (CHIP) 179
Claim 179
CMS 179
Cost Report 179
Customary Charges 179
Day Treatment Services 179
Department 179
Developmental Disability (DD) 179
Director 179
Dual Eligible 179
Durable Medical Equipment (DME) 179
Early Periodic Screening, Diagnosis, & Treatment (EPSDT) 179
Educational Services 179
Evidence-Based Interventions 179
Evidence-Informed Interventions 180
Facility 180
Fiscal Intermediary 180
Human Services Field 180
A Through K 38
Airborne Precautions 38
Approved Fecal Specimens 38
Bite or Other Exposure to Rabies 38
Board 38
Cancer Data Registry of Idaho (CDRI) 38
Cancers 38
Carrier 38
Case 38
Cohort System 38
Communicable Disease 39
Contact 39
Contact Precautions 39
Day Care 39
Department 39
Director 39
Division of Public Health Administrator 39
Droplet Precautions 39
Exclusion 39
Extraordinary Occurrence of Illness Including Clusters 39
Fecal Incontinence 39
Food Employee 39
Foodborne Disease Outbreak 39
Health Care Facility 39
Health Care Provider 40
Health District 40
Health District Director 40
Idaho Food Code 40
Investigation 40
Isolation 40
Act 95
Agency 96
Department 97
I Through O 180
Idaho Medicaid Provider Handbook 180
Inspection of Care Team (IOCT) 180
In-State Care 180
Instrumental Activities of Daily Living (IADL) 180
Integration 180
Interim Reimbursement Rate (IRR) 180
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) 180
Level of Care 181
Level of Support 181
Licensed Bed Capacity 181
Lower of Cost or Charges 181
Major Movable Equipment 181
Medicaid-Related Ancillary Costs 181
Medical Assistance (Medicaid) 181
Medical Necessity (Medically Necessary) 181
Medical Supplies 181
Medical, Social, & Developmental Assessment (MSDA) Summary 181
Minimum Data Set (MDS) 181

Minor Movable Equipment 181
Nominal Charges 182
Order 182
Ordinary 182
Orthotic 182
L Through Z 40
Laboratory 40
Laboratory Director 40
Livestock 40
Medical Record 40
Outbreak 40
Personal Care 40
Physician 40
Quarantine 40
Rabies Post-Exposure Prophylaxis (rPEP) 41
Rabies-Susceptible Animal 41
Residential Care Facility 41
Restrictable Disease 41
Restriction 41
Severe Reaction to Any Immunization 41
Significant Exposure to Blood or Body Fluids 41
Standard Precautions 41
State Epidemiologist 41
Suspected Case 41
Vaccination of an Animal Against Rabies 41
Veterinarian 42
Waterborne Outbreak 42
Working Day 42
P Through Z 182
Participant 182
Personal Assistance Agency (PAA) 182
Plan Developer 182
Plan Monitor 182
Plan of Care 182
Primary Care Provider (PCP) 182
Prior Authorization (PA) 182
Property Rental Rate 182
Prosthetic Device 182
Provider 183
Provider Status Review 183
Qualified Intellectual Disabilities Professional (QIDP) 183
Quality Improvement Organization (QIO) 183
Recoupment 183
Recreational Services 183
Referral 183
Related Entity 183
Resource Utilization Groups (RUG) 183
Restrictive Intervention 183
Retrospective Review 183
Rural Hospital-Based Behavioral Care Unit 183
Service Coordination 183
Service Plan 183
Skilled Nursing Care 183
Supervision 183
Supports 184
Third Party 184
Utilization Control (UC) 184
Utilization Control Team (UCT) 184
Vocational Services 184
Qualified Expert 97
Radiation Safety Program 97
Definitions -- A Through Z 103
Abuse 103
ADA 103
Adult Residential Care Facility 103
Advocate 103
Center-Based Services 103
Communicable Disease 103
Deficiency 103
Department 103
Developmental Disability 103
Developmental Disability Agency (DDA) 104
Exploitation 104
Health Care Professional 104
Immediate Jeopardy 104
Implementation Plan 104
Maladaptive Behavior 104
Medication 104
Natural Setting 104
Neglect 104
Participant 104
Physical Restraint 104
Plan Of Service 104
Repeat Deficiency 104
Residential Habilitation 104
Substantial Compliance 104
Survey 104
Time Out 105
Definitions & Abbreviations 130
Advance Directive 130
Behavior Plan 131
Call System 131
Cognitive Impairment 131
Criminal Offense 131
Dementia 132
Developmental Disability 132
Direct Resident Access 132
Elopement 132
Hourly Adult Care 132
Incident 133
Legal Guardian or Conservator 133
Maladaptive Behavior 133
Medication 133
Medication Administration 133
Medication Assistance 133
Mental Disorders 133
Mental Illness 133
Outside Services 133
Owner 133
Personnel 134
Portable Heating Device 134
Provisional License 134
Publicly Funded Program 134
Punishment 134
Relative 134
Repeat Deficiency 134
Reportable Incident 134
Scope 135
Self-Administration of Medication 135
Survey 135
Surveyor 135
Therapeutic Diet 135
Toxic Chemical 135
Traumatic Brain Injury (TBI) 135
Unlicensed Assistive Personnel (UAP) 135
Variance 136
Definitions & Abbreviations A Through E
Abuse 130
Accident 130
Activities 130
Activities of Daily Living 130
Administrator 130
Administrator's Designee 130
Adult 130
Advocate 130
Ambulatory Person 130
Assessment 130
Authentication 131
Authorized Provider 131
Chemical Restraint 131
Complaint 131
Complaint Investigation 131
Core Issue 131
Deficiency 131
Department 132
Director 132
Electronic Signature 132
Exit Conference 132
Exploitation 132
Definitions & Abbreviations F Through N 132
Follow-Up Survey 132
Governmental Unit 132
Immediate Danger 132
Inadequate Care 132
Independent Mobility 133
License 133
Licensing Agency 133
Neglect 133
Negotiated Service Agreement 133
Nursing Assessment 133
Definitions & Abbreviations O Through Z 133
Personal Assistance 134
Physical Restraint 134
Pressure Injury 134
PRN 134
Resident 135
Residential Assisted Living Facility 135
Room & Board 135
Story 135
Substantial Compliance 135
Substantial Evening Meal 135
Supervision 135

Definitions For Vital Statistics 340
Authorized Representative 340
Certificate 340
Individuals With a Direct & Tangible Interest 340
Parent 341
Public Health 341
Putative Father 341
Registrar 341
Research 341
Statistical Purposes 341
Definitions, IDAPA 16.05.01, Use & Disclosure Of Department Records 339
Authorization 339
Confidential Information 339
Consent 339
Department 339
Guardian Ad Litem 339
Identifying Information 340
Informal Representative 340
Legal Representative 340
Minimally Necessary 340
Need-to-Know 340
Psychotherapy Notes 340
Delegation Of Powers & Duties 42, 87
Delegation of Powers & Duties 87
Denial Of An Application 109
Before Denial Is Final 109
Causes For Denial 109
Dental Services 243
Coverage & Limitations 243
Dental Coverage for Adults 243
Dental Coverage for Children 243
Definitions 243
Adult 243
Child 243
Participant Eligibility 243
Procedural Requirements 243
Administer the Dental Benefit 243
Appeals 243
Authorization 243
Grievances 243
Provider Qualifications & Duties 243
Provider Reimbursement 244
Quality Assurance 244
Selective Contract For Dental Coverage 243
Department Evaluation For Lock-In 334
Department's Written Decision Regarding Application For Certification 108
Developmental Therapy 308
Coverage & Limitations 308
Individual Program Plan (IPP) Procedural Requirements 309
Intake 309
IPP Changes 309
IPP Development 309
Individual Service Plan (ISP) Requirements 308
Intake 308
Plan Changes 308
Procedural Requirements 309
Comprehensive Developmental Assessment 309
Documentation Requirements 310
Informed Objectives 311
PIP Requirements 310
Specific Skill Assessments 310
Provider Qualifications & Duties 311
Collaboration with Other Providers 311
Developmental Specialists 311
Developmental Therapy Paraprofessionals 311
Diabetes Education & Training Services
Coverage & Limitations
Concurrent Diagnosis 217
No Substitutions 217
Services Limited 217
Coverage And Limitations 217
Participant Eligibility 217
Participants with Diabetes 217
Participants with Pre-Diabetes 217
Procedural Requirements 217
Provider Qualifications & Duties 217
Diabetes Management Program 218
The National Diabetes Prevention Program 218
Diphtheria 63
Handling of Report 64
Investigation & Response 63
Reporting Requirements 63
Restrictions - Contacts 64
Restrictions - Daycare Facility 64
Restrictions - Health Care Facility 64
Direct 111
Disclosure of Information 38
District Court Appeals, Complaints & Requests For Reconsideration 339
DMEPOS
Coverage & Limitations 240
Corsets & Braces 240
Custom Fitting 240
Electronically Powered or Enhanced Prosthetic or Orthotics 241
Guaranteed Fit 240
Modification & Repairs 240
New Equipment 240
Replacement Prosthesis or Orthotic Device 240
Shoes & Accessories 241
Supply Coverage 240
Temporary Lower Limb Prosthesis 241
Procedural Requirements 241
Orders 241
Rental Procedures 241
Provider Reimbursement 241
Date of Service 241
Items Included in Per Diem Excluded 241
Warranties & Cost of Repairs 241
Quality Assurance 242
Documentation For Audits 191
Additional Documentation 192
Cost Allocation Process 191
Expenditure Documentation 191
Revenue Documentation 192
Documents Incorporated By Reference 37
Compendium of Animal Rabies Prevenstion and Control, 2016 37
Guideline for Isolation Precautions in Hospitals 37
Human Rabies Prevention -- United States, 2008 37
Nationally Notifiable Diseases Surveillance System - Case Definitions 37
Standards for Cancer Registries, Volume II, Data Standards & Data Dictionary 37
Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis 37
Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies
Recommendations of the Advisory Committee on Immunization Practices, 2010 38
Dual Eligibles 327
Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) 240

E

Early Intervention Services 226
Echinoccocosis 64
Investigation 64
Reporting Requirements 64
Effect Of Enforcement Action Against A License 139
Electronic Visit Verification (EVV) 236
Emergency Preparedness Policies Written Procedures 142
Emergency Preparedness Requirements 142
Emergency Generators 142
Relocation Agreements 142
Emergency Transportation Services
Coverage & Limitations 257
Air Ambulance Service 257
Co-Payments 258

Local Transport Only 257
Participant Eligibility 257
Procedural Requirements 258
Air Ambulance 258
Non-Emergency Transport PA Required 258
Services Subject to Review 258
Provider Qualifications & Duties 258
Air Ambulance 258
Licensure Required 258
Provider Reimbursement 258
Ambulance Reimbursement Base Rate 258
Multiple Providers 259
Response & Evaluation 259
Round Trips & Standby 259
Treat & Release 259
Encephalitis, Viral Or Aseptic 64
Investigation 64
Reporting Requirements 64
Enforcement Action 170
Enforcement Action Of A Consultant 170
Enforcement Action Of A Provisional License 173
Enforcement Action Of Civil Monetary Penalties 170
Assessment Amount for Civil Monetary Penalty 171
Civil Monetary Penalties 170, 171
Failure to Pay 171
Notice of Civil Monetary Penalties & Appeal Rights 171
Payment of Penalties 171
Enforcement Action Of Limit On Admissions 170
Notification of Limit on Admissions 170
Reasons for Limit on Admissions 170
Enforcement Action Of Revocation Of Facility License 173
Reasons for Revocation or Denial of a Facility License 173
Revocation of Facility's License 173
Enforcement Action Of Temporary Management 172
Need for Temporary Management 172
Notice of Temporary Management 172
Powers & Duties of the Temporary Manager 172
Responsibility for Payment of the Temporary Manager 173
Termination of Temporary Management 173
Who May Serve as a Temporary Manager 172
Enforcement Actions 170
Enforcement Process 123
Determination Of Remedy 123
Failure To Comply 124
Immediate Jeopardy 123
Repeat Deficiency 123
Enhanced DD Services 296
EPSDT Services 261
Coverage & Limitations 262
Additional Services 262
Eyeglasses Under EPSDT 262
Interperiodic Screens 262
Definitions 261
Interperiodic Medical Screens 261
Periodic Medical Screens 261
Participant Eligibility 261
Provider Qualifications & Duties 262
Escherichia coli O157
h7 & Other Shiga-Toxin Producing E. coli (STEC) 64
Handling of Report 65
Investigation 64
Reporting Requirements 64
Restrictions - Day Care Facility 65
Restrictions - Food Service Facility 65
Restrictions - Health Care Facility 65
Essential Providers 244
Exception To The Related Organization Principle 203
Non-Exclusive Relationship 204
Sales & Rental of Extended Care Facilities 204
Supplying Organization 204
Exceptions To Requirement For Authorization 343
Advocates & Guardians 344
Child Protection Agency 345
Collaborative Staffing 345
Department Business, Monitoring & Legal Functions 344
Duty to Warn or Report 344
Elected State Official 345
Emergencies 344
Fugitives & Missing Persons 344
Informal Representatives 345
Law Enforcement 345
Legally Authorized Agency 345
Licensure 344
Multidisciplinary Staffing 345
Exceptions To Residential Provider-Owned Or Controlled Setting Qualities 284
Excluded Services 204
Expiration & Renewal Of License 138
Application for License Renewal 138
Existing License 138
Extraordinary Occurrence Of Illness, Including Clusters 65
Handling of Report 65
Investigation 65
Reporting Requirements 65

F

Facility License Application 137
Building Evaluation Fee 138
Failure to Complete Application Process 138
Identification of the Licensed Administrator 138
License Application 137
Written Request for Building Evaluation 138
Facility Standards For Agencies Providing Center-Based Services 114
Accessibility 114
Environment 114
Evacuation Plans 115
Fire & Safety Standards 114
Fire Drills 115
Food Safety & Storage 115
Housekeeping & Maintenance Services 115
Facility, Safety, & Health Standards 114
Family Planning 233
Family Planning Services
Coverage & Limitations 233
Contraceptive Supplies 233
Exceptions to Sterilization Time Requirements 233
Requirements for Sterilization Performed Due to a Court Order 233
Sterilization 233
Participant Eligibility 233
Hysterectomies 233
Sterilization Procedures 233
Procedural Requirements 234
Provider Reimbursement 234
Fees 91
Radiation Licensing Fees 91
Radiation Safety Program Fee 92
X-Ray Shielding Plan Review & Fee 92
Financial Requirements 140
Funds at Discharge 140
Safeguarding of Funds 140
Statement 140
Fire And Life Safety Standards For Existing Buildings Licensed For Seventeen Or More Residents And Multi-Story Buildings 161
Fire And Life Safety Standards For Existing Buildings Licensed For Three Through Sixteen Residents 161
Fire And Life Safety Standards For New Buildings Housing Seventeen Or More Residents And Multi-Story Buildings 161
Fire And Life Safety Standards For New Buildings Housing Three Through Sixteen Residents 161

Food Poisoning, Foodborne Illness, & Waterborne Illness 65
Handling of Report 66
Investigation 65
Reporting Requirements 65
Food Preparation & Service 165
Disposable Items 165
Food Preparation 165
Food Preparation Area 165
Frequency 165
Food Service Facility - Reporting & Control Measures 53
Food Employee Health Examination 53
Food or Beverage Transmitted Disease in a Communicable Form 53
Notification of Disease in a Communicable Form 53
Food Supply 165
Forms 353
Annual Report Form 353
Form for Lobbyist Registration 353
Form for Report of Alleged Violation of Sunshine Law 354
Form for the Appointment & Certification of Political Treasurer 354
Forms for the Disclosure of Campaign Finances by Candidates & Political Committees 354
Monthly Report Form 353
FQHC & RHC
Rate Setting Methodology 246
Annual Filing Requirements 247
Change in an Encounter Rate Due to a Change in Scope of Services 246
New Providers to Idaho Medicaid 246
Prospective Payment System 246
FQHC & RHC Services
Coverage & Limitations 244
Chiropractor Services 245
Clinical Psychologist Services 245
Incidental Services & Supplies 245
Licensed Clinical Professional Counselor Services 245
Licensed Clinical Social Worker Services 245
Licensed Dentist & Dental Hygienist Services 245
Licensed Marriage & Family Therapist Services 245
Licensed Masters Social Worker Services 245
Licensed Professional Counselor Services 245
Licensed Social Worker Services 245
Nurse Practitioner or Clinical Nurse Specialist Services 245
Other DOPL Licenses 245
Other Payable Services 245
Pharmacist Services 245
Physician Assistant Services 244
Physician Services 244
Podiatrist Services 245
Visiting Nurse Services 245
Definitions 244
Change in Intensity of Services 244
Encounter 244
Federally Qualified Health Centers (FQHCs) 244
Medicare Cost Report Period 244
Medicare Economic Index (MEI) 244
Rural Health Clinic (RHC) 244
Reimbursement Methodology 245
FQHC or RHC Encounter 245
Payment 245
Frequency of Inspections 139
Complaint Investigations 139
Correction of Non-Core Issues 139
No Core Issues 139

G

Galactosemia 66
General Consent & Disclosure Requirements 341
General Participant Provisions 184
General Payment Procedures 188
Appeals Process 190
Cost Reporting 189
For Providers Subject to Retrospective Cost Settlement 189
Other Noninstitutional Services 189
Procedures for Medicare Cross-Over Claims 190
Provided Services 188
Provider Reimbursement 189
Services Normally Billed Directly to the Patient 189
General Provider Provisions 184
General provisions 95
General Reimbursement Provisions for Institutional Providers 191
General Staffing Requirements 110
DSP Duties 111
Parent Or Legal Guardian Of Participant 111
Supervisor Duties 111
General Staffing Requirements For Agencies
Administrator Qualifications and Duties 110
Agency Administrator Duties 111
Direct Service Provider (DSP) Qualifications 111
Supervisor Qualifications 111
Volunteer Workers In A DDA 111
General Training Requirements
Certification Training 114
Ongoing Training 114
Giardiasis 66
Investigation 66
Reporting Requirements 66
Restrictions - Day Care Facility 66
Restrictions - Food Service Facility 66
Restrictions - Health Care Facility 66
Grievance Policy 118

H

Haemophilus Influenzae Invasive Disease 66
Handling of Report 66
Investigation 66
Reporting Requirements 66
Restrictions - Day Care Facility 66
Restrictions - School 67
Handling Of Overpayments & Underpayments For Specified Providers 190
Interest Charges 190
Recovery Methods 191
Handling of Report 53
Anthrax 54
Brucellosis 54
Leptospirosis 54
Lyme Disease 54
Plague 54
Psittacosis 54
Q Fever 54
Trichinosis 54
Tularemia 54
Hantavirus Pulmonary Syndrome 67
Handling of Report 67
Investigation 67
Reporting Requirements 67
Hard To Place Children 349
HCBS 283
A&D Waiver Services 283
Consumer-Directed Services 283
DD 1915i & Waiver Services 283
Participant Eligibility 284
Conditions for Termination 284
Continuous Eligibility for Children Under Age Nineteen 284
Failure to Meet Requirements 284
Federal & State Eligibility Requirements 284
PCS 283
Provider Qualifications & Duties 283
Youth Empowerment Services (YES) for Children with Serious Emotional Disturbance

(SED) 283
HCBS Exceptions 283
Judicial Restrictions 283
Legal Guardians 283
Payees appointed by the SSA 283
HCBS Person-Centered Plan Requirements 284
Plan Signatures 284
Residential Requirements 284
Setting Selection 284
Health Home 317
Coverage & Limitations 317
Eligibility Requirements. 317
Procedural Requirements. 317
Provider Qualifications & Duties 317
Provider Reimbursement. 318
Health Information 339
Health Policy 116
Address Needs Of Participants 116
Ensure Personnel Are Disease-Free 116
Medication Standards 116
Protect Participants 116
Hemolytic-Uremic Syndrome (HUS) 67
Investigation 67
Reporting Requirements 67
Hepatitis A 67
Exclusion - Food Service Facility 67
Investigation 67
Reporting Requirements 67
Restrictions - Day Care Facility 67
Restrictions - Health Care Facility 68
Restrictions - Household Contacts 68
Testing Without an Informed Consent 67
Hepatitis B 68
Carrier Status 68
Investigation 68
Reporting Requirements 68
Testing Without an Informed Consent 68
Hepatitis C 68
Investigation 69
Reporting Requirements 68
Testing Without an Informed Consent 69
Home & Community-Based Services (HCBS) 283
Home Health Services 235
Coverage & Limitations 235
Limitations 235
Requirements 235
Services 235
Settings 235
Procedural Requirements 235
Home Health Plan of Care 235
Orders 235
Provider Reimbursement 236
Home Health Services 236
Medical Supplies, Equipment, & Appliances 236
Hospice 322, 323
Coverage & Limitations 323
Definitions 323
Benefit Period 323
Election Period 323
Hospice Agency 323
Eligibility 323
Inpatient Payment Limitations 325
Limitation Cap 325
Maximum Allowable Inpatient Days 325
Patient Liability 326
Physician Payments 325
Hospice Employed Physicians 325
Independent Physicians 326
Volunteer Physicians 325
Procedural Requirements 323
Election Procedures 323
Election Revocation 324
Hospice Change 324
Hospice Election 324
Physician Certification 323
Plan of Care 324
Provider Qualifications & Duties 324
Reimbursement 324
Continuous Home Care 324
General Inpatient Care 325
Inpatient Respite Care 325
Routine Home Care 324
Service Intensity Add-On 325
Reimbursement Cap 326
Additional Amount for NF Residents 326
Adjustment to Overall Cap 326
Calculation of Cap 326
Certified Mid-Month 326
Number of Participants 326
Overall Cap 326
Total Payment 326
Hospital Records 349
Hospital Services
Definitions 206
Administratively Necessary Day (AND) 206
Allowable Costs 206
All-Patient Refined Diagnosis Related Group (APR-DRG) 206
Capital Costs 206
Charity Care 206
Critical Access Hospitals (CAH) 206
Current Year 206
Disproportionate Share Hospital (DSH) Allotment Amount 207
Disproportionate Share Hospital (DSH) Survey 207
Disproportionate Share Threshold 207
Hospital Inflation Index 207
Inpatient Customary Hospital Charges 206
Low-Income Revenue Rate 207
Medicaid Inpatient Day 207
Medicaid Utilization Rate (MUR) 207
Obstetricians 208
On-Site 208
Outpatient Services Customary Hospital Charges 207
Reasonable Costs 208
Uninsured Patient Costs 208
Upper Payment Limit 208
Provider Reimbursement 209
Adequacy of Cost Information 212
Adjustment for Disproportionate Share Hospitals (DSH) 210
Administratively Necessary Days (AND) Reimbursement Rate 209
Audit Function 212
Hospital Swing-Bed Reimbursement 209
Interim Cost Settlements 212
Interim Reimbursement Rates for Providers Subject to Cost Settlement 212
Non-Appealable Items 212
Out-of-State Hospitals 212
Payment Procedures 209
Hourly Adult Care Requirements 142
Accommodations 143
Assistance with Medications 142
Cost of Hourly Adult Care 142
Documentation 143
Hourly Adult Care 143
Hours for Care 142
Individuals Accepted 142
Services Offered 142
Staffing 143
Human Immunodeficiency Virus (HIV) 69
Investigation 69
Reporting Requirements 69
Testing Without an Informed Consent 69
Human Resources 350
Human T-Lymphotropic Virus 69
Investigation 69
Reporting Requirements 69

I

ICF/IID 272
Allowable Costs 275
Auto & Travel Expense 275
Bad Debts 275
Bank or Finance Charges 275
Compensation of Owners 275
Contracted Service 276
Depreciation 276
Dues, Licenses, or

Subscriptions 276
Employee Benefits 276
Employee Recruitment 276
Entertainment Costs Related to Patient Care 276
Food 276
Home Office Costs 276
Insurance 276
Interest 276
Lease or Rental Payments 276
Malpractice or Public Liability Insurance 276
Payroll Taxes 276
Principle 276
Property Costs 276
Property Insurance 276
Repairs or Maintenance 276
Salaries 276
Supplies 276
Taxes 276
Capped Cost 279
Cost Data to Determine the Cap 280
Cost Ranking 280
Costs Subject to the Cap 279
Payments to Non ICF/IIDs 280
Per Diem Costs 279
Costs Excluded From Cap 280
Cost Increases Over 3% 281
Decreases 281
Excess Inflation 281
Increases to Per Participant Day Costs 281
Prospective Negotiated Rates 281
Coverage & Limitations 273
Coverage 273
Limitations 274
Temporary Absence 274
Exempt Costs 280
Non-Allowable Costs 276
Accelerated Depreciation 276
Acquisitions 276
Charity Allowances 276
Consultant Fees 276
Franchise Fees 276
Fund Raising 276
Goodwill 277
Holding Companies 277
Interest to Finance Unallowable Costs 277
Medicare Costs 277
Non-patient Care Related Activities 277
Organization 277
Pharmacist Salaries 277
Prescription Drugs 277
Related Party Interest 277
Related Party Non-allowable Costs 277
Related Party Refunds 277
Self-Employment Taxes 277
Vending Machines 277
Occupancy Adjustment Factor 277
Fixed Costs 277
New Facility 277
Occupancy Adjustment 277
Occupancy Levels 277
Participant Eligibility 272
ICF/IID Eligibility Criteria 273
Required Information for Applications 272
Principle Prospective Rates 279
Procedural Responsibilities 274
Annual Recertification 274
Determinations 275
Reporting Requirements 274
Supplemental On-Site Visit 275
Property Reimbursement 279
Costs of Related Party Leases 279
Interest 279
Lease Payments 279
Property Insurance 279
Property Taxes 279
Straight-Line Depreciation 279
Property Reimbursement Limitations 282
Home Office & Day Treatment Property Costs 282
Property Leases 282
Property Rental Rate Reimbursement 281
Facility Sale 282
Rate Calculation 281
Provider Qualifications & Duties 275
Direct Care Staff Hours 275
Direct Care Staffing Levels 275
Phase-In Period 275
Recapture Of Depreciation 277
Amount Recaptured 278
Time Frame 278
Reimbursement 275
Reporting System 278
Adequate Financial Disclosure 278
Basis for Reimbursement 278
Criteria For Evaluating Policies & Procedures 278
Statistical Resources 278
Reporting System Principle & Application 278
Change of Management or Ownership 279
Cost Report Requirements 278
Preparer 278
Report Criteria 278
Reporting by Chain Organizations or Relative Providers 278
Reporting Period 279
Special Reports 278
Retrospective Settlement 280
Excluded Costs 280
Failure to Meet Conditions 280
First Time Provider 280
Fraudulent Claims 280
New ICF/IID Living Unit 280
Ownership Change 280
Special Rates 282
Altered Services 283
Emergency 283
New Admissions to a Community ICF/IID 283
Significant Change in Condition 283
Impounding 96
Incorporation By Reference 90, 128, 177
Estimated Useful Lives of Depreciable Hospital Assets, 2023 Revised Edition 177
Mammography Quality Standards Act Regulations, Part 900 90
National Council of Radiation Protection (NCRP) Report No. 147 90
Provider Reimbursement Manual (PRM) 177
Suggested State Regulations for Control of Radiation, Volume 1 90
Indian Health Service (IHS) Clinic Services
Coverage & Limitations 247
Provider Reimbursement 247
Dispensing Fee for Prescriptions 247
Payment Procedure 247
Third Party Liability Not Applicable 247
Individual Provider Requirements 184
Express Exclusions 184
Practice Authority 184
Provider Eligibility 184
Standard of Care 184
Infant/Toddler Program 350
Injunction To Prevent Operation Without Certificate 125
Inpatient Hospital Services
Coverage & Limitations 208
Diagnosis Related Group (DRG) Review & Audits 208
Exceptions & Limitations 208
Extended Stay 208
Initial Length of Stay 208
Procedural Requirements 208
Certification of Medical Necessity 208
Individual Plan of Care 208
Request for Extended Stay 209
Provider Qualifications & Duties 209
Quality Assurance 213
Approval Timeframe 213
Department Provisions 213
Method of Notice 213
Procedural Information 213
QIO Information 213
Inspections 97
Investigation & Control Of Reportable Diseases 50
Closure of Schools & Places of

Public Assembly 50
Inspection - Right of Entry 50
Inviolability of Placards 50
Order for Isolation 51
Order for Quarantine 51
Order to Report for Examination 51
Responsibility & Authority 50
Sexually Transmitted Infection Contacts 52
Transportation of Patients With Communicable Disease 50
Verification of Diagnosis and Case Classification 50
Investigational Procedures Or Treatments 205
Additional Clinical Information 206
Focused Case Review 205
Investigations, Audits, & Enforcement 328

L

Labeling, Storage, & Transportation 97
Laboratory & Radiology Services 226
Coverage & Limitations 226
Laboratory Services 226
Radiology Services 226
Definitions 226
Independent Laboratory 226
Laboratory or Clinical Laboratory 226
Proficiency Testing 226
Quality-Control 226
Reference Laboratory 226
Provider Qualifications & Duties 227
Laboratory & Radiology Requirements 227
Use of Reference Laboratories 227
Provider Reimbursement 227
Provider of Service 227
Specimen Collection Fee 227
Quality Assurance 227
Lead Poisoning 69
Investigation 69
Reporting Requirements 69
Leak Testing & Replacement Of Sealed Sources 96
Legal Authority 37, 90, 102, 127, 177, 338
Legionellosis 69
Investigation 70
Reporting Requirements 70
Leprosy (Hansen's Disease) 70
Investigation 70
Reporting Requirements 70
Restrictions - Examination of Contacts 70
Leptospirosis 70
Handling of Report 70
Investigation 70
Reporting Requirements 70
License Modification, Suspension, or Revocation 100
License Renewal And Fees 98
License Renewal 98
Licensing Fee Due Dates and Late Penalties 98
Radiation Safety Program Flat Fee 98
Recognition of Other Licenses 98
License Requirements And Application 97
Federal Facilities 97
Insurance and Financial Responsibility 98
License Application 98
Licensed Midwife (LM) Services 218
Licensing 91
Licensing and Registration Requirements for Industrial Radiography Operations 96
Licensing Requirements 136
Administrator 136
Change in Corporate Shares 137
Current License 136
Display of Facility License 137
Distinctive Business Name 136
Issuance of License 136
Licensee Responsibility 137
Licensure of Radiation Machine Facilities 96
Licensure Of Radiation Machine Facilities, (Services) - And Associated Healthcare Professionals 96
Liens & Estate Recovery 328
Definitions 328
Adequate Consideration 328
Authorized Representative 329
Discharge From a Medical Institution 329
Home 329
Institutionalized Participant 329
Lawfully Residing 329
Permanently Institutionalized 329
Personal Property 329
Real Property 329
Residing in the Home on a Continuous Basis 329
Termination of a Lien 329
Undue Hardship 329
Undue Hardship Waiver 329
Lien During Lifetime Of Participant 329
Determination of Permanent Institutionalization 329
Filing of Lien During Lifetime of Participant 330
Lien Imposed During Lifetime of Participant 329
Notice of Determination of Permanent Institutionalization and Hearing Rights 330
Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Participant 330
Renewal of Lien Imposed During Lifetime of Participant 330
Termination of Lien Imposed During Lifetime of Participant 330
Limitations & Exclusions 332
Certain Life Estates 332
Excluded Land 332
Expenses Deducted From Estate 332
Interest on Claim 332
Limitations on Estate Claims 332
Marriage Settlement Agreement or Other Such Agreement 332
Purpose of the Undue Hardship Exception 332
Set Aside of Transfers 333
Notification To Department 329
Request For Notice 333
Forms - Content 333
Notice - Hearing 333
Webpages for Forms 333
Requirements For Estate Recovery 331
Assets in Estate Subject to Claims 331
Lien Imposed Against Estate of Deceased Participant 331
Notice of Estate Claim 331
Recovery From Estate of Spouse 331
Value of Estate Assets 331
Listeriosis 70
Investigation 70
Reporting Requirements 70
LM Services
Coverage & Limitations 218
Maternity & Newborn 218
Medication 218
Participant Eligibility 218
Provider Quality Assurance Activities 218
Location Of Documents & Records 97
Lock-In Defined 334
Lock-In Participant Notification 334
Lock-In Procedures 334
Appeal Stays Restriction 334
Lock-In Duration 334
Participant Responsibilities 334
Payment to Providers 335
Regional Programs Manager 335
Long-Term Care Facility Payment 192
Lyme Disease 70
Handling of Report 71
Investigation 70
Reporting Requirements 70

M

Machines Required To Be Licensed 91
Malaria 71
Investigation 71
Reporting Requirements 71

Testing Without an Informed Consent 71
Managed Care For Duals 327
Coverage & Limitations 328
Definitions 327
Dual Eligible 327
Evidence of Coverage 327
Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) 327
Idaho Medicaid Plus (IMPlus) 327
Medicare Advantage Organizations (MAOs) 327
Medicare Advantage Plan 327
Medicare/Medicaid Coordinated Plan (MMCP) 327
Passive Enrollment 327
Eligibility & Enrollment 328
Exclusions 328
Exemptions 328
Mandatory Counties 328
Passive Counties 328
Voluntary Counties 328
Program Authority 328
IMPlus 328
MMCP 328
Managing Participant Behavior 120
Physical Restraints and Time Out Requirements 121
Techniques to Manage Maladaptive Behavior 121
Written Informed Consent 121
Maple Syrup Urine Disease 71
Measles (Rubeola) 71
Handling of Report 71
Investigation 71
Reporting Requirements 71
Restrictions - Day Care Facility & School 71
Restrictions - Health Care Facility 71
Medicaid Basic Plan Covered Services 206
Sub Area
Hospital Services 206
Medicaid Enhanced Plan Covered Services 263
Medical Assistance Procedures 184
Medical Care 350
Medical Services 215
Coverage & Limitations 215
Adult Physicals 215
Injectable Vitamins 215
Screening Mammograms 216
Tonometry 216
Weight Loss Surgical Procedures 216
Diagnostic Screening Clinics 216
Billings 216
Multidisciplinary Assessments & Consultations 216
Provider Qualifications 217
Participant Eligibility 215
Procedural Requirements 216
Provider Qualifications & Duties 216
Locum Tenens Claims & Reciprocal Billing 216
Misrepresentation of Services 216
Weight Loss Surgical Procedures 216
Medical Transportation Services 257
Medicare Savings Program 327
AABD Effective Date 327
Neither AABD nor SSI Effective Date 327
SSI Effective Date 327
Medicare/Medicaid Coordinated Plan (MMCP) 327
Medication 117
Assistance With Medication 117
Disposal of Medications 118
Handling Of Participant's Medication 117
Medication Record 118
Self-Administration Of Medication 117
Meningitis, Viral Or Aseptic 72
Investigation 72
Reporting Requirements 72
Mental Illness 350
Menu & Diet Planning 164
Facilities Licensed for Seventeen Beds or More 164
Facilities Licensed for Sixteen Beds or Less 164
Menu 164
Therapeutic Diets 164
Methicillin-Resistant Staphylococcus Aureus (MRSA) 72
Investigation 72
Reporting Requirements 72
Restrictions - Day Care Facility 72
Restrictions - Food Service Facility 72
Restrictions - Health Care Facility 72
Restrictions - School 72
Minor' s Consent Regarding Infectious, Contagious Or Communicable Disease 350
Mumps 72
Investigation 73
Reporting Requirements 72
Restrictions 73
Myocarditis, Viral 73
Investigation 73
Reporting Requirements 73

N

Negotiated Service Agreement 155, 156
Neisseria Gonorrhoeae 73
Investigation 73
Isolation - Health Care Facility 73
Prophylaxis of Newborns 73
Reporting Requirements 73
Neisseria Meningitidis Invasive Disease 73
Handling of Report 73
Investigation 73
Reporting Requirements 73
Restrictions - Day Care Facility 73
Restrictions - Health Care Facility 74
Restrictions - School 74
NEMT Services
Coverage & Limitations 260
NEMT Services 260
Travel-Related Services 260
Definitions 259
Contracted Transportation Provider 259
NEMT 259
Transportation Broker 260
Travel-Related Services 260
Duties Of The Transportation Broker 260
Authorize NEMT Services 260
Call Center 260
Contract With Transportation Providers 260
Coordinate & Manage 260
Reimburse Contracted Transportation Providers 260
Safe & Professional Transportation 260
Reimbursement Methodology 261
NF
BCU Eligible Days 270
BCU Qualifications 270
Behavioral Care Unit (BCU) Rates 270
Direct Care Costs 270
New Owner 270
Cost Limits 269
Coverage & Limitations 266
Limitations 267
Minimum Coverage 266
Skilled Services 266
Definitions 265
Distressed Facility 269
Annual Review 270
Department Determination 269
Discretionary Factors 269
Prospective Application 270
Eligibility 265
Authorization 266
Determination 265
Eligibility Coordination & Specialized Service Needs 268
Appeals 268
Categorical Determinations 268
Non-Compliance Penalty 268
Specialized Services 268
Nurse Aide Training & Competency Evaluation

Programs (NATCEPS) 272
Occupancy Adjustment Factor 271
Adjustment Exemption 272
Fixed Costs 272
Occupancy Adjustment 271
Occupancy Levels 271
Out-Of-State Facilities 269
Patient Liability 266
Payments For Temporary Absences 272
NF Occupancy Limits 272
Payment Limits 272
Time Limits 272
Prepayment Screen & Determination Of Entitlement To Medicaid Payment For NF Care & Services 268
Principle For Rate Setting 269
Procedural Responsibilities 267
Amount Exceeded 267
Change of Status 267
Changes of Resident's Income 267
Other Patient Financial Information 267
Provider Qualifications & Duties 268
Application 268
Licensure & Certification (L&C) 268
Rate Development 269
Rate Setting 269
Payments 269
Rate Adjustment 269
Recapture Of Depreciation 272
Amount Recaptured 272
Time Frame 272
Reviews 270
Department Review 270
Facility Review 270
Special Rates 270
Determination 270
Effective Date 270
Limitation 270
Payment for Qualifying Residents 271
Prospective Rate Treatment 270
Reporting 270
Special Rate for NF Ownership Change or Closure 271
Treatment of Special Rates In Future Rate Setting Periods 271
NF & ICF/IID Reimbursement 193
Accounting System 195
Application of Reasonable Cost Principles 193
Application of Related Party Transactions 193
Audit Standards & Requirements 196
Audits 195
Compensation to Relatives 193
Failure to File 195
Filing Dates 195
Home Office Cost Principles 193
Idaho Owner-Administrator Compensation 194
Legal Consultant Fees & Litigation Costs 200
Patient Funds 199
Reasonable Cost Principles 193
Nonresident Deer & Elk Tag Quotas 33
Disabled American Veteran Hunt Tag Quotas 34
Exceptions 34
General Hunt Tag Quotas 34
Norovirus 74
Exclusions - Food Service Facility 74
Investigation 74
Reporting Requirements 74
Restrictions - Day Care Facility 74
Restrictions - Health Care Facility 74
Restrictions - School 74
Notice Of Enforcement Remedy 125
Notice To Agency 125
Notice To Public 125
Notices, Instructions & Reports To Workers 97
Notifications 97
Novel Influenza A Virus 74
Investigation 74
Reporting Requirements 74
Restrictions 74
Nursing Facilities (NF) 265
Nutritional Services 218

O

Ongoing 114
On-Site Inspection 98
Optometrist Services
Coverage & Limitations 218
Organ Transplants 263
Coverage & Limitations 263
Reimbursement 263
General 263
Living Donor Costs 263
Organization Record Requirements 111
Accessibility Of Agency Records 111
General Record Requirements 111
Participant Records 112
Staff Records 111
Organization Reporting 116
Reporting Incidents To The Department 116
Reporting Requirements 116
Organizations Approved Through National Accreditation 110
Criminal History Background Check Requirements 110
Staff Records 110
The Current Accreditation Verification Or Report 110
Orientation Training Requirements 167
Content for Training 167
Number of Hours of Training 167
Timeline for Completion of Training 167
Other Provider Services 217
Outpatient Hospital Services
Coverage & Limitations 213
Co-Payments 213
Services Are Provided On-Site 213
Definitions 213
Procedural Requirements 213
Follow-Up for Emergency Room Patients 214
Review Prior to Delivery 214
Provider Reimbursement 214

P

Participant Lock-In 333
Participant Responsibility 184
Participant Rights 119
Method Of Informing Participants Of Their Rights 120
Participant Rights Provided Under Idaho Code 119
Participant Utilization Control Program 333
PCS
Coverage & Limitations 293
Medical Care & Services 293
Non-Medical Care & Services 293
Participant Limitations 294
Place of Service 293
Provider Limitations 294
Service Exclusions 293
Definitions 292
PCS 292
PCS Family Alternate Care Home 292
Eligibility 292
Level of Care 292
Redetermination 292
Significant Changes 293
Procedural Requirements 294
PA 294
Provider Notification 295
Record Requirements in Participant Homes 294
Service Plan 294
Supervision 294
Provider Qualifications & Duties 295
Children's PCS Delivered in a Provider's Home 295
Direct Care Workers 295
Health Screen 295
Personal Assistance Agency (PAA) & Fiscal Intermediaries 295

- Training for Participants with DD 295
- Quality Improvement (QI) 296
- Reimbursement 295
- Calculated Fee 295
- CFH & RALF Rates 296
- PAA Rates 296
- Rate Methodology 295
- Supervisor RN & QIDP Rates 296

PCS & Aged & Disabled Waiver Service Cost Surveys 200
- ERE 200
- Expenditures by Provider Type 200
- Wage Rates 200

PDN
- Definitions 264
- PDN RN Supervisor 264
- PDN Services 264
- Primary RN 264
- Limitations 264
- Participant Eligibility 264
- Provider Ordered 264
- RN Assessment 264
- Service Plan 264
- Status Updates 264
- Provider Qualifications & Duties 264
- Oversight of LPNs 265
- PDN Redetermination 265
- Physician Responsibility 265
- RN Responsibilities 265

Penalties For Lock-In Noncompliance 335

Penalty Provisions 42

Personal Care Services (PCS) 292

Persons Required To Report Reportable Diseases, Conditions, & School Closures 42
- Hospital or Health Care Facility Administrator 42
- Laboratory Director 42
- Others Required to Report Reportable Diseases 42
- Persons in Charge of Food Establishments 42
- Physician 42
- School Administrator 42

Pertussis 74
- Investigation 75
- Reporting Requirements 75
- Restrictions - Day Care Facility 75
- Restrictions - Health Care Facility 75
- Restrictions - School 75

Phenylketonuria 75

Plague 75
- Handling of Report 75
- Investigation 75
- Prophylaxis of Contacts 75
- Reporting Requirements 75
- Restrictions - Health Care Facility 75

Plauge
- Restrictions - Day Care Facility 75
- Restrictions - School 75

Pneumococcal Invasive Disease In Children Less Than Eighteen Years Of Age 76
- Investigation 76
- Reporting Requirements 76
- Restrictions - Day Care Facility 76
- Restrictions - School 76

Pneumocystis Pneumonia (PCP) 76
- Investigation 76
- Reporting Requirements 76

Podiatrist Services
- Coverage & Limitations 219
- Definitions 218
- Acute Foot Conditions 218
- Chronic Foot Diseases 218
- Participant Eligibility 219
- Acute Condition 219
- Chronic Disease 219

Policies & Procedures 139

Policies And Procedures Regarding Development Of Restrictive Interventions
- Protected Rights 120

Poliomyelitis 76
- Immunization of Personal Contacts 76
- Investigation 76
- Reporting Requirements 76
- Restrictions - Day Care Facility 76
- Restrictions - School 76

Preadmission Screening & Resident Review Program (PASRR) 268
- Change in Status 268
- Level I Screening 268
- Level II Screening 268

Pregnancy-Related Services
- Coverage & Limitations 262
- Individual & Family Social Services 262
- Maternity Nursing Visit 263
- Nursing Services 263
- Qualified Provider Risk Assessment & Plan of Care 263
- Risk Reduction Follow-Up 263
- Definitions 262
- Individual & Family Social Services 262
- Maternity Nursing Visit 262
- Nursing Services 262
- Risk Reduction Follow-Up 262
- Provider Qualifications & Duties 263
- Individual & Family Social Services 263
- Risk Reduction Follow-Up 263
- Provider Reimbursement 263

Prescription Drugs 227
- Coverage & Limitations 227
- Additional Criteria for Coverage 228
- Additional Excluded Drugs 229
- Covered Drug Products 228
- Excluded Drug Products 228
- General Drug Coverage 227
- Limitation of Quantities 229
- Preferred Drug List (PDL) 227
- Definitions 227
- Participant Eligibility 227
- Procedural Requirements 229
- Dispensing Procedures 229
- Request for PA 229
- Response to Request 229
- Return of Unused Prescription Drugs 229
- Supplemental Rebates 229
- Provider Qualifications & Duties 230
- Enrollment 230
- Out-of-State Providers 230
- Provider Reimbursement 230
- 340B Covered Entity Reimbursement 231
- Cost Appeal Process 232
- Limitations on Payment 232
- Pharmacy Reimbursement 230
- Reimbursement for Drugs Dispensed by Other Provider Types 232

Preventing Spread Of Health Hazards From Dead Human Bodies 52
- Burial 52
- Embalming 52
- Notification of Health Hazard 52

Prevention Services 225

Preventive Health Assistance (PHA)
- Coverage & Limitations 225
- Point System 225
- Premiums 226
- Weight Management Program 225
- Definitions 225
- Participant Eligibility 225
- Behavioral PHA 225
- Wellness PHA 225
- Procedural Requirements 226
- Behavioral PHA 226
- Wellness PHA 226
- Provider Reimbursement 226

Private Duty Nursing (PDN) 263

Provider Agreements 185
- Crossover Only Providers 186
- Enforcement Actions & Terminations 185
- General 185
- Non-billing Ordering, Referring, & Prescribing (ORP) 186

Provider Application Process 185
- Application 185
- Denial of Provider Agreement 185
- Disclosure of Information 185

Provisional 105
Psittacosis 77
Handling of Report 77
Investigation 77
Reporting Requirements 77

Q

Q Fever 77
Handling of Report 77
Investigation 77
Reporting Requirements 77
Quality Assurance, Behavior Management, and Specific Program Requirements 118
Quarterly Inventory 96

R

Rabies - Human, Animal, & Post-Exposure Prophylaxis (rPEP) 77
City or County Authority 79
Handling of Report 77
Investigation 77
Management of Exposure to Rabies 78
Reporting Requirements 77
Radiation Safety Requirements For Industrial Radiographic Operations 96
Recipient Explanation Of Medicaid Benefits (REOMBS)
Participant Response 335
Participant Unable to Respond 335
Recipient Explanation Of Medicaid Benefits (REOMBs) 335
Reciprocal Recognition of Out-Of-State Radiation Machines 96
Addition to Part B, Section B.16 -- New Subsection d 96
Modification to Part B, Section B.16.a.iv 96
Reciprocity 97
Records 191
Availability of Records 191
Provider Refusal 191
Retention of Records 191
Undocumented Services 191
Records Of Decedents 348
Coroners & Medical Examiners 348
Family Members & Others 348
Funeral Directors 348
Law Enforcement 348
Personal Representatives 348
Records of Leak Testing of Sealed Sources & Devices Containing DU 97
Records of Quarterly Inventory 97
Relapsing Fever, Tick-Borne & Louse-Borne 79
Investigation 79
Reporting Requirements 79
Related Party Transactions 192
Cost to Related Organizations 192
Costs Not Related to Patient Care 192
Determination of Common Ownership or Control 192
Exception 192
Interest Expense 192
Principle 192
Renewal & Expiration Of The Certificate 110
Expiration Without Timely Request For Renewal 110
Renewal And Expiration Of The Certificate
Renewal Request 110
Report Contents & After-Hours Reporting 44
Report Contents & Method Of Reporting
After Hours Notification 44
How To Report 44
Report Contents 44
Report Of Disclosures Of Health Information 347
Documentation of Disclosure 348
Documented Disclosures 347
Maintenance of Documentation 348
Pending Investigation 348
Request for Report of Disclosures 348
Reportable Diseases with Special Control Measures 58
Reportable Or Restrictable Diseases, Conditions & Reporting Requirements 45
Reporting Crime In Emergencies 346
Reporting Of Crime On Premises 346
Requirements For Additional Physical Standards 150
Fire District 150
Medical Accessibility 150
Roads 150
Requirements For Admission Agreements
Advance Directive 145
Billing Practices, Notices, & Procedures for Payments & Refunds 145
Contested Charges 145
Emergency Transfers 145
Initial Resident Assessment & Care Plan 143
Medication Responsibilities 145
Notification of Liability Insurance Coverage 145
Notification of Payee Requirements 145
Resident Belongings Responsibility 145
Resident Permission to Transfer Information 145
Resident Personal Fund Responsibilities 145
Resident Responsibilities 145
Restrictions on Choice of Care or Service Providers 145
Smoking Policy 146
Staffing 145
Transition to Publicly Funded Program 146
Written Agreement 144
Requirements For Admission Agreements For Private-Pay Residents
Services, Supports, & Rates 144
Requirements For An Agency's Quality Assurance Program
Health And Safety Supports 119
Measurable Outcomes 119
Requirements For An Organization's Quality Assurance Program 119
Participant Records 119
Policies and Procedures 119
Staff Records 119
Requirements For Building Construction & Physical Standards 147
Approval 148
Call System 150
Construction Changes 147
Dietary Standards 150
Dining, Recreation, Shower, Bathing & Living Space 149
Heating, Ventilation, & Air-Conditioning (HVAC) 149
Lighting 148
Plans & Specifications 147
Plumbing 149
Resident Sleeping Rooms 149
Secure Environment 150
Toilets & Bathrooms 148
Ventilation 149
Walls & Floor Surfaces 148
Requirements For Emergency Actions And Fire Drills 162
Fire Watch 163
Report of Fire 162
Requirements For Environmental Sanitation 150
Garbage & Refuse Disposal 151
Housekeeping & Maintenance Services 152
Insect & Rodent Control 151
Linen & Laundry Facilities & Services 151
Sewage Disposal 151
Toxic Chemicals 152
Water Supply 151
Requirements For Facility Records 156
Additional Resident Records 158
Admission Records 157
As Worked Schedules 160
Behavior Documentation 158
Dietary Records 159
Discharge Records 158
Electronic Records 156

Fire & Life Safety Records 160
Hourly Adult Care Documentation 159
Paper Records 156
Personnel Records 159
Record Confidentiality 156
Records for Water Supply 159
Resident Admission & Discharge Register 159
Residential Care Records 156
Water Supply 159
Requirements For Fire And Life Safety Standards 161
Requirements For Food & Nutritional Care Services 164
Requirements For Furnishings, Equipment, & Supplies 163
Basic Services 163
Common Shared Furnishings 163
Resident Sleeping Room Furnishings 163
Resident Telephone Privacy 163
Requirements For Furnishings, Equipment, Supplies, & Basic Services
Basic Supplies 164
Personal Supplies 164
Resident Bed 163
Resident Supplies & Furnishings 164
Requirements For Infection Control 160
Reporting of Individual with an Infectious Disease 161
Staff with an Infectious Disease 160
Standard Precautions 161
Requirements For Medications and Treatments 153
Behavior Modifying Medication 154
Controlled Substances 154
Discontinued & Expired Prescriptions 153
Medication Distribution 153
Requirements For Resident Admissions 143
Pre-Admission 143
Requirements For Staffing Standards 166
Cardio-Pulmonary Resuscitation (CPR) and First Aid Certification 166
Detached Buildings or Units 166
On-Duty Staff Up & Awake During Residents' Sleeping Hours 166
Personal Management 166
Sufficient Personnel 166
Requirements For Termination Of Admission Agreement 146
Conditions for Termination of the Admission Agreement 146
Facility Responsibility During Resident Discharge 146
Notification 146
Receipt of Appeal 147
Resident's Appeal of Involuntary Discharge 146, 147
Written Notice of Discharge 146
Requirements For The Licensed Nurse Responsibility Requirements
Change in Resident Health Status 152
Requirements For The Licensed Nursing Assessment 152
Pre-Admission Assessment 152
Quarterly Nursing Assessments 152
Recommendations 152
Self-Administered Medication 153
Requirements For The Licensed Registered Nursing Assessment
Current Medication Orders & Treatment Orders 152
Progress of Previous Recommendations 153
Resident & Facility Staff Education 153
Resident Medications & Therapies 152
Requirements For Training Of Facility Personnel 167
Requirements To Protect Residents From Abuse 165
Requirements To Protect Residents From Exploitation 166
Requirements To Protect Residents From Inadequate Care 166
Requirements To Protect Residents From Neglect 166
Resident Safety Requirements 140
Behavior Management for Residents 141
Facility Operations, Inspections, Maintenance, and Testing 141
Hazardous Materials 141
Mechanical Equipment 142
Notification of Changes to Resident Health or Mental Status 141
Provided Care & Services by Staff 141
Response to Accidents, Incidents, or Allegations of Abuse, Neglect, or Exploitation of Residents 141
Response to Emergencies 141
Smoking Requirements 142
Residential Habilitation Agencies Termination Procedures 123
Emergency Termination 123
Termination with Agreement 123
Termination with Notice 123
Respiratory Syncytial Virus (RSV) 79
Restriction On Certification 110
Restrictions 54
Restrictions - Daycare Facility 54
Restrictions - Food Service Facility 55
Restrictions - Health Care Facility 56
Revocation Of Certificate 124
Causes For Revocation Of The Certificate 124
Revocation Of The Organization's Certificate 124
Reye Syndrome 79
Investigation 79
Reporting Requirements 79
Rocky Mountain Spotted Fever 80
Investigation 80
Reporting Requirements 80
Rubella - Including Congenital Rubella Syndrome 80
Investigation 80
Reporting Requirements 80
Restrictions - Day Care Facility 80
Restrictions - Health Care Facility 80
Restrictions - Personal Contact 80
Restrictions - Schools 80

S

Salmonellosis - Including Typhoid Fever 80
Handling of Report 80
Investigation 80
Reporting Requirements 80
Restrictions - Chronic Carrier 80
Restrictions - Non-Typhi Salmonella 81
Restrictions - Salmonella Typhi 81
SBS
Coverage & Limitations 249
Evaluation & Diagnostic Services 249
Excluded Services 249
Reimbursable Services 249
Participant Eligibility 248
Age 248
Parental Consent 248
Procedural Requirements 251
Documentation of Qualifications of Providers 252
Evaluations & Assessments 251
IEP & Other Service Plans 251
One Hundred Twenty Day Review 252
Recommendations or Referrals Required 252
Requirements for Cooperation 252
Service Detail Reports 251
Provider Qualifications & Duties 252
Behavioral Consultation 253
Behavioral Intervention 252
Crisis Intervention 253

- Habilitative Skill Building 254
- Interdisciplinary Training 254
- Medical Equipment & Supplies 255
- Nursing Services 255
- Occupational Therapy & Evaluation 255
- Personal Care Services (PCS) 255
- Physical Therapy & Evaluation 255
- Psychological Evaluation 255
- Psychotherapy 255
- Skills Building/Community-Based Rehabilitation Services (CBRS) 255
- Social History & Evaluation 256
- Speech/Audiological Therapy 256
- Therapy Paraprofessionals 256
- Transportation 256
- Provider Reimbursement 256
- Matching Funds 256
- Recoupment of Federal Share 256
- Quality Assurance & Improvement 257
- Audit 257
- Quality Improvement 257
- Service-Specific Participant Eligibility 248
- CHIS 248
- Personal Care Services 249
- Skills Building/Community Based Rehabilitation Services (CBRS) 248

School - Reporting & Control Measures 53
- Determination Disease Is No Longer Communicable 53
- Restrictable Diseases 53
- Restrictions - Attendance 53
- Restrictions - Work 53
- School Closure 53

School-Based Service
- Definitions 247
- Individual Educational Plan (IEP) 247
- School-Based Services (SBS) 247
- Serious & Persistent Mental Illness (SPMI) 247

Scope 37, 90, 95, 103, 128, 177, 338
- Application 103
- Certification 103

Serious Threat To Health Or Safety 346
- Apprehension by Law Enforcement 346
- Escape From Law Enforcement 346
- Prohibition on Disclosure 346

Service Coordination 318
- Coverage & Limitations 318
- Contacts 319
- Crisis Assistance 319
- Exclusions 319
- Limitations 319
- Monitoring & Follow-Up 319
- Plan Assessment & Reassessment 319
- Plan Development 319
- Definitions 318
- Conflict of Interest 318
- Crisis 318
- Participant Eligibility 318
- Adults 318
- Children 318
- Plan Development – Assessment 321
- Procedural Requirements 320
- Conflict of Interest 320
- Contact & Availability 320
- Documentation 320
- Freedom of Choice 320
- Plan Development 320
- Prior Authorization 320
- Provider Qualifications & Duties 320
- Case Loads 321
- Health, Safety, & Fraud Reporting 321
- Paraprofessional Requirements 321
- Provider Agreement 321
- Service Coordinator Requirements 321
- Supervision 321
- Supervisor Requirements 321
- Reimbursement 321
- Delivered Prior to Assessment 322
- Duplication 321
- Medical Institutionalization 322
- Payment 322

Service Coordination Plan 321
Services Provided by Developmental Disabilities Agencies 105
Services, Treatments, & Procedures Not Covered By Medicaid 204
- Experimental Treatments or Procedures 205
- Service Categories Not Covered 204
- Types of Treatments & Procedures Not Covered 204

Setting Requirements 115
- Accessibility 115
- Environment 115

Setting Requirements For Agencies Delivering Community-Based Services
- Promote Inclusion 116

Severe Acute Respiratory Syndrome (SARS) 82
- Investigation 82
- Isolation 82
- Reporting Requirements 82

Severe Reaction To Any Immunization 82
- Handling of Report 82
- Investigation 82
- Reporting Requirements 82

Shigellosis 82
- Exclusions - Food Service Facility 83
- Handling of Report 82
- Investigation 82
- Reporting Requirements 82
- Restrictions - Day Care Facility 82
- Restrictions - Health Care Facility 83
- Restrictions - Household Contacts 83

Smallpox 83
- Investigation 83
- Reporting Requirements 83
- Restrictions - Day Care Facility 83
- Restrictions - Health Care Facility 83
- Restrictions - Public Gatherings 83
- Restrictions - School 83
- Restrictions - Working 84

Smoking Requirements 143
- Combustible Supplies & Flammable Items 143
- Designated Smoking Areas 143
- Smoking in Bed 143
- Unsupervised Smoking 143

Special Disease Investigations 52
Specialized Reimbursement
- Certain HCBS & CHIS 200
- Applicable HCBS & CHIS Programs 201
- Cost Survey Procedures 201
- Quality Incentives 202
- Rate Setting Methodology 201
- Timing, Description, & Rate Review Results 201
- Electronic Visit Verification (EVV) 203
- EVV Requirements 203
- Services Requiring EVV 203

Specific Consent & Disclosure Requirements 348
Specific Pregnancy-Related Services 262
Specific Provider Reimbursement 192
Specific Requirements - Protection & Advocacy Agencies 350
Specific Requirements for Radiographic Personnel Performing Industrial Radiography 97
Staff Training Requirements
- Intervention Procedures to Ensure Safety of Residents and Staff 141

Staffing Requirements 311
- Agency Staffing Requirements 312
- Paraprofessional Standards 311

Standards For A DDA center and Adult

Residential Care Facility 121
Construction Changes 121
Environment 121
Environment Safety Standards 122
Fire Safety Standards 122
Food Safety and Nutrition 122
Housekeeping and Maintenance Services 122
Streptococcus Pyogenes (Group A Strep) Infections 84
Investigation 84
Reporting Requirements 84
Restrictions - Daycare Facility 84
Restrictions - Health Care Facility 84
Restrictions - School 84
Substance Abuse 350
Age Sixteen & Over 350
Drug Abuse 350
Supervisor 111
Syphilis 84
Investigation 84
Reporting Requirements 84
Testing Without an Informed Consent 84

T

Termination Of Parental Rights 350
Testing For Certain Reportable Diseases When Informed Consent Is Not Possible 50
Testing Without Informed Consent 58
Hepatitis A 58
Hepatitis B 58
Hepatitis C 58
HIV 58
Malaria 58
Syphilis 58
Tetanus 84
Investigation 85
Reporting Requirements 84
Therapy Services 236
Coverage & Limitations 237
Non-Covered Therapy Services 237
Service Limitations 238
Therapy Services 237
Definitions 236
Duplicate Services 236
Feeding Therapy 236
Maintenance Program 236
Occupational Therapy Services 236
Physical Therapy Services 236
Speech-Language Pathology Services 237
Therapeutic Procedures 237
Therapist 237
Therapy Professional 237
Therapy Services 237
Participant Eligibility 237
Procedural Requirements 238
Orders 238
Therapy Plan of Care 238
Provider Reimbursement 238
Home Health Agencies 238
Hospital Services 239
Independent Therapists 238
Long-term Care Facilities 239
School-based Services 239
Quality Assurance Activities 239
Documentation 239
Therapist Conditions & Requirements 239
Third Party Liability 187
Accident Determination 188
Billing Third Parties First 187
Current Resource 187
Determining Liability 187
Seeking Third Party Reimbursement 187
Subrogation of Legal Fees 188
Subrogation of Third Party Liability 188
Third Party Payments 188
Withholding Payment 187
Toxic Shock Syndrome 85
Investigation 85
Reporting Requirements 85
Training Requirements 113
CPR and First Aid Training 113
Initial And Annual Training 113
Participant Specific Training 113
Training Requirements For Facilities Admitting Residents With A Diagnosis Of Dementia, Mental Illness, Developmental Disability, Or Traumatic Brain Injury (TBI) 168
Dementia 168
Developmental Disability 168
Mental Illness 168
Traumatic Brain Injury 169
Transition Management 291
Limitations 292
Provider Qualifications 291
Service Description 292
Transmissible Spongiform Encephalopathies (TSE), Including Creutzfeldt-Jakob Disease (CJD) & Variant CJD (VCJD) 85
Autopsy 85
Investigation 85
Reporting Requirements 85
Transportation Policy 116
Adequate Staffing 116
Laws, Rules, And Regulations 116
Licenses, Certifications, And Insurance For Drivers And Vehicles 116
Preventative Maintenance Program 116
Trichinosis 85
Handling of Report 85
Investigation 85
Reporting Requirements 85
Tuberculosis 85
Active Pulmonary Tuberculosis - Definition 85
Cure of Tuberculosis - Definition 85
Investigation 85
Reporting Requirements 85
Restrictions - Day Care Facility 86
Restrictions - Health Care Facility 86
Restrictions - Household Contacts 86
Restrictions - School 86
Tularemia 86
Handling of Report 86
Investigation 86
Reporting Requirements 86
Types Of Certificates Issued 105
Initial Certificate 105
One-Year Certificate 105
Provisional Certificate 105
Three-Year Certificate 105

U

Use & Disclosure Of Confidential Information 342
Alternative Communication 343
Collateral Contact 343
Discovery 343
Identity 342
Order of Court or Hearing Officer 343
Referent 343
Restriction on Disclosure of Health Information 343
Utilization Logs 97

V

Variances 136
Continuing A Variance 136
Decision to Grant a Variance 136
Revocation of Variance 136
Temporary Variance 136
Written Request 136
Venereal Diseases 350
Victim Of Other Crime 346
Best Interest of the Individual 346
Incapacity of Victim or Emergency Circumstance 346
Violations 96
Vision Services 242
Coverage & Limitations 242
Eye Examinations 242
Eyeglasses & Contacts 242
Non-Covered Items 242
Participant Responsibility 243
Vision Therapy 242
Provider Reimbursement 243
Vital Statistics
Disclosure For Research, Public Health Or Statistical Purposes 351
Procedures For Requesting Information 351

Certified Copy 351
Expedited Copy 351
Registry Of Putative Fathers 351
Vital Statistics -- Verification Of Data 351
Administrative Fact of Death Verifications 351
Verifications 351
Verifications to Protect a Person's Property Right 351

W

Waivers 125
Where To Report Reportable Diseases & Conditions 43
Cancer Data Registry of Idaho (CDRI) 44
Department of Health and Welfare, Bureau of Environmental Health and Communicable Disease Epidemiology Program 43
Health District I - Panhandle Health District 43
Health District II - North Central District Health Department 43
Health District III - Southwest District Health Department 43
Health District IV - Central District Health 43
Health District V - South Central District Health Department 43
Health District VI - Southeastern District Health Department 43
Health District VII - Eastern Idaho Public Health 44
Inter-Agency Notification 44
Women, Infants & Children (WIC) Program 351
Written Interpretations 128

X

X-Ray Facility And Operator Training Requirements 99
Facility Requirements 99
Operator Training Requirements 99
X-Ray Machine Performance Standards 99
Compliance 99
Image Quality 99
Maintenance and Calibration 99
Radiation Output 99
Safety Features 99
X-Ray Machine Quality Control and Quality Assurance 98
Quality Assurance 99
Quality Control 98
X-Ray Shielding Plan Approval 98

Y

Yersiniosis, Other Than Plague 86
Investigation 87
Reporting Requirements 86
Restrictions - Food Service Facility 87
YES HCBS State Plan Option
Coverage & Limitations 322
Person-Centered Planning 322
Respite Care 322
Independent Assessment 322
Contact 322
Evaluation 322
History 322
Redetermination 322
Youth Empowerment Services (YES) HCBS State Plan Option 322