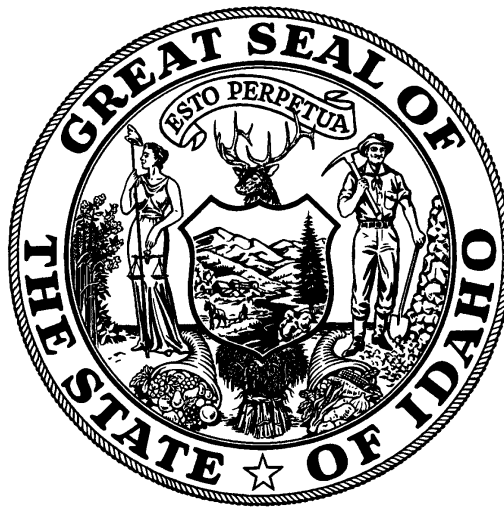


PENDING RULES

COMMITTEE RULES

REVIEW BOOK

Submitted for Review Before
House Health & Welfare Committee
63rd Idaho Legislature
Second Regular Session



Prepared by:

*Office of the Administrative Rules Coordinator
Department of Administration*

January 2016

HOUSE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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**IDAPA 15 - OFFICE OF THE GOVERNOR
COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED**

15.02.02 - VOCATIONAL REHABILITATION SERVICES

DOCKET NO. 15-0202-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-5407, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 231 - 235](#).

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:

These rule changes will have no effect on the state general fund. There is a negative fiscal impact, but the changes will be federally funded.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Raelene Thomas, Management Assistant, at (208) 334-3220, ext. 124.

DATED this 6th Day of November, 2015.

Raelene Thomas
Management Assistant
Idaho Commission for the Blind and Visually Impaired
341 W. Washington St.
P. O. Box 83720
Boise, ID 83720-0012
Phone: (208) 334-3220 ext.124
Fax: (208) 334-2963

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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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 67-5407, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

These changes are necessary to keep up with the increasing costs associated with vocational rehabilitation services. These rule changes increase ICBVI's contribution of goods and services to Vocational Rehabilitation clients. The VR Policy Manual also requires an update in terminology to be consistent with Rehabilitation Services Administration regulations.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

These rule changes will have no effect on the state general fund. There is a negative fiscal impact, but the changes will be federally funded.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the proposed changes are beneficial to the public and must be updated due to the adoption of a new case management system by the Commission.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Raelene Thomas, Management Assistant, at (208) 334-3220, ext. 124.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 3rd Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 15-0202-1501

110. ELIGIBILITY.

01. Eligibility Requirements. Eligibility of a client for vocational rehabilitation services shall be based upon a determination by the Commission that: (4-2-08)

- a.** The client is blind or visually impaired; (4-2-08)
- b.** The client's blindness or visual impairment constitutes or results in a substantial impediment to employment; and (4-2-08)
- c.** There is a reasonable expectation that vocational rehabilitation services will benefit the client in

terms of securing, retaining, or regaining employment. (4-2-08)

d. The client has a disability priority which can include no significant disability (NSD), significant disability (SD), or most significant disability (MSD). ()

02. Residency Requirements. A client must have legal residence status, be able to complete an employment eligibility verification, and be present in the state. (4-2-08)

03. Presumptive Eligibility. Individuals who are current SSI or SSDI beneficiaries are presumed to be eligible for vocational rehabilitation services unless the Commission can demonstrate by clear and convincing evidence that such individuals are incapable of benefiting in terms of an employment outcome from vocational rehabilitation services due to the severity of their disability. (4-2-08)

04. Certificate of Ineligibility. If an individual is determined ineligible for services, a certificate of ineligibility will be prepared and a copy provided the individual or the individual's representative. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

300. PAYMENT POLICY.

01. Upper Limits. In order to ensure a reasonable cost to the Commission's vocational rehabilitation program for provision of certain enumerated services, and in accordance with 34 CFR 361.50, the Commission hereby establishes upper limits on dollar amounts it will contribute to clients for certain categories of services provided as part of an implemented IPE pursuant to Section 210 of these rules: (4-2-08)

a. Education expenses - public in-state institutions. ()

i. Education expenses, including fees, tuition, and health insurance costs, for enrollment at public in-state institutions: Ninety percent (90%) of the actual costs for two (2) semesters per federal fiscal year at the institution of enrollment. If the client receives any grant or scholarship (except merit based scholarships), it shall be applied first for tuition or fees and books and supplies, in that order, before any expenditure of funds by the Commission. (5-8-09)()

ii. The Commission may assist with an advanced degree based on the rehabilitation needs of the individual client, but only if the client is unable to achieve employment with an undergraduate degree. ()

b. Education expenses - private in-state institutions. ()

i. Education expenses, including fees, tuition, and health insurance costs, for enrollment at Idaho private in-state colleges, private in-state vocational technical schools, private in-state universities, and other private in-state education and training institutions and including enrollment in summer school: Ninety percent (90%) of actual costs for two (2) semesters per federal fiscal year up to an amount not to exceed actual costs per federal fiscal year at ~~Boise State University, Idaho State University, or University of~~ a public Idaho, ~~whichever is higher~~ college or university. If the client receives any grant or scholarship (except merit based scholarships), it shall be applied first for tuition or fees and books and supplies, in that order, before any expenditure of funds by the Commission. (5-8-09)()

ii. The Commission may assist with an advanced degree based on the rehabilitation needs of the individual client, but only if the client is unable to achieve employment with an undergraduate degree. ()

c. Education expenses - out-of-state institutions. Education expenses, including fees and tuition, for enrollment at out-of-state colleges, universities, vocational technical schools, and other education and training institutions, and including enrollment in summer school: Ninety percent (90%) of actual costs for two (2) semesters per federal fiscal year up to an amount not to exceed actual costs per federal fiscal year that would be incurred at ~~Boise State University, Idaho State University, or University of~~ a public Idaho, ~~whichever is higher~~ college or

university. If the client receives any grant or scholarship (except merit based scholarships), it shall be applied first for tuition or fees and books and supplies, in that order, before any expenditure of funds by the Commission.

~~(5-8-09)~~()

i. If the client must attend an out-of-state institution because the course of study is not offered within the state of Idaho, the Commission, at its discretion may pay the “usual and customary” charges for fees and tuition up to the established limits. (4-2-08)

ii. If the course of study is offered in-state, but because of the additional costs caused by the accommodation for disability, it would be more cost effective for the Commission to have the client attend the out-of-state educational institution, the Commission, at its discretion, may pay the usual and customary fees and tuition charges for the out-of-state educational institution up to the established limit. (4-2-08)

iii. If the client chooses to attend an out-of-state institution even though the course of study is offered within the state of Idaho, the Commission will only pay an amount equal to the maximum cost for fees and tuition, up to the established limit, at the in-state-institution offering the course of study that is closest geographically to the Commission regional office assisting the client. (4-2-08)

d. Books and supplies. Actual costs of required books and supplies, including expenditures for books and supplies required for attendance of summer school. If the client receives any grant or scholarship (except merit based scholarships), it shall be applied first for tuition or fees, books and supplies, in this order, before any expenditure of funds by the Commission.

~~(5-8-09)~~()

e. Medical exams including written report. (4-2-08)

i. Specialist exam by M.D.: ~~Two~~ To be paid at specialist's rate not to exceed three hundred dollars (~~\$2300~~) maximum, plus actual cost of related procedures such as (e.g., x-rays). (4-2-08)()

ii. Psychological exam by licensed psychologist: Two hundred fifty dollars (~~\$2050~~) plus actual cost of psychometric tests. (4-2-08)()

iii. Ophthalmologist/Optometrist exam: ~~Two~~ Three hundred dollars (~~\$2300~~) plus actual cost of visual field exam or other necessary tests. (4-2-08)()

(1) Low vision exam: ~~One~~ To be paid at specialist's rate not to exceed two hundred ~~twenty-five~~ dollars (~~\$125200~~). (4-2-08)()

(2) Follow-up low vision consultation: ~~Fifty~~ Sixty-five dollars (~~\$565~~). (4-2-08)()

(3) Eye report: Twenty-five dollars (\$25). (4-2-08)

iv. Eye glasses or contact lenses: ~~Eighty~~ Two hundred dollars (~~\$8200~~) for frames costs and the usual and customary cost for lenses and contact lenses. ~~Nine~~ Twelve hundred dollars (~~\$91,200~~) for biotics. ~~(5-8-09)~~()

v. Audiologist exam: ~~Eighty-five~~ To be paid at specialists rate not to exceed two hundred dollars (~~\$85200~~). (4-2-08)()

vi. Physical exam (general basic medical): ~~Sixty-five~~ Two hundred dollars (~~\$65200~~) plus actual cost of additional procedures and tests. (4-2-08)()

f. Psychotherapy/Counseling sessions: Up to ~~ten (10) hourly sessions at eighty~~ one hundred dollars (~~\$8100~~) per hour and up to ten (10) sessions. Exceptions may be made by Rehabilitation Services Chief. (4-2-08)()

g. Medication and medical supplies (including diabetic supplies): Three hundred dollars (\$300) per month for up to three (3) months, during which client must apply for reduced cost or free medication programs provided by drug companies or other sources of comparable benefits, including Medicaid, Medicare Part D, or other

insurance. After the expiration of the three (3) month period, the commission will pay the state Medicaid rate for medication and medical supplies. (4-2-08)()

h. Dental work, including but not limited to cleaning, fillings, extractions, crowns, and dentures: ~~Five hundred~~ One thousand dollars (\$~~51,000~~) per case. (4-2-08)()

i. Transportation. (4-2-08)

i. Public conveyance (bus, van, airfare): Actual cost. (4-2-08)

ii. Transportation ~~costs~~ services associated with personal vehicle usage with or without personal driver: Two hundred dollars (\$200) per month within a twenty (20) mile radius (in-town commuting) and three hundred dollars (\$300) per month for commuting from greater than a twenty (20) mile radius (out-of-town commuting). ~~The Commission does not provide funds for a client's purchase of a motor vehicle~~ Exceptions can be approved by the Rehabilitation Services Chief. (5-8-09)()

iii. ICBVI may reimburse for state mileage rate for client transportation services or may reimburse for the actual cost of gasoline. ()

~~iv.~~ Cab subsidy programs (Scrip) must be used by clients where available. (4-2-08)

j. Maintenance: Three thousand dollars (\$3,000) per federal fiscal year and no more than five hundred dollars (\$500) per month. There is no limit on the number of months a client can receive maintenance up to the three thousand dollar (\$3,000) limit per federal fiscal year. These maximums also apply to room and board for post secondary education and to any rent payments. (3-29-12)

i. The Commission will not pay maintenance for basic living expenses incurred by a client that are not directly related to the client's participation in an IPE for vocational rehabilitation services. (4-2-08)

ii. If a client is participating in the Assessment and Training Center (ATC) and is not commuting to ATC for training, the maximum per month is three hundred dollars (\$300) for maintenance up to the three thousand dollars (\$3,000) per federal fiscal year. Over three hundred dollars (\$300) a month or three thousand dollars (\$3,000) per fiscal year requires approval from the VR Services Chief. Maintenance will not be paid during the ATC breaks. (3-29-12)

k. Copy fees: ~~Fifteen~~ Twenty dollars (\$~~15~~20) for obtaining a copy of any report or other record from an outside agency or entity required by the Commission in order to determine a client's eligibility or otherwise provide vocational rehabilitation services. (4-2-08)()

l. Tools and equipment: ~~One~~ Two thousand dollars (\$~~1~~2,000) per case depending on employment goal. Value of tools and equipment provided to client from existing Commission inventory will count towards the ~~one~~ two thousand dollar (\$~~1~~2,000) limit. If there is a change in client's employment outcome, the client shall return the original tools and equipment to the Commission. The Commission will not provide or purchase additional tools or equipment for the client for any new employment outcome until the original tools and equipment have been returned to the Commission. (4-2-08)()

m. On-the-Job training fees: Three thousand dollars (\$3,000). (4-2-08)

n. Computers including hardware and software: ~~One~~ Two thousand dollars (\$~~1~~2,000) per case. If the Commission determines that a change in computers is necessary, as appropriate, the client shall return the original computer to the Commission. The Commission will not provide or purchase a new or different computer for the client until the original computer has been returned. (4-2-08)()

o. Self-employment plans: Three thousand dollars (\$3,000), to include tools and equipment, excluding adaptive technology and computers. (4-2-08)()

p. Child care: Three hundred dollars (\$300) per child per month. The client shall apply and use

Department of Health and Welfare child care funding as a comparable benefit before any expenditure of Commission funds towards IPE related child care. (4-2-08)

g. Vehicle purchase: The Commission may provide finances to modify and/or repair an already owned vehicle to make it accessible for the client's use under the following circumstances: ()

i. The cost of the modification and/or repair cannot exceed the current Blue Book fair trade in value of the vehicle: ()

ii. The client must maintain insurance on the vehicle for replacement cost: ()

iii. The Commission can aid in the purchase of a used vehicle or utility trailer as long as they are a part of the approved self-employment plan or a part of the Business Enterprise Program. ()

r. Physical, Occupational, and Speech Therapy: The Commission may cover one hundred dollars (\$100) per session at maximum of ten (10) sessions per case. Exceptions can be made by rehabilitation Services Chief. ()

02. Exclusion of Surgery ~~and Organ Transplantation.~~ (4-2-08)

~~a.~~ The Commission does not provide funds for a client's surgery when the surgery is the only service required for the client to achieve an employment outcome or otherwise return to work. (4-2-08)()

~~b.~~ The Commission does not provide funds for a client's organ transplantation. (4-2-08)

03. Authorization to Purchase. When purchasing services from a vendor, the Commission requires a written authorization be issued prior to, or on the beginning date of, service. If services are provided without an approved written authorization to purchase, the Commission reserves the right to refuse payment on the vendor's invoice. Verbal authorization for a service may only be given by the ~~Rehabilitation~~ ~~Services~~ ~~Chief~~ or the Commission ~~Administrator~~. If a client fails to show up for an appointment, the client shall be responsible for payment of any charges resulting from the client's failure to show up for the appointment. (4-2-08)()

04. Exception Policy. Any and all exceptions to the upper limits established by Subsection 300.01 of these rules will be reviewed on an individual case basis, and require approval by the ~~Rehabilitation~~ ~~Services~~ ~~Chief~~ of the Commission. (4-2-08)()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.01 - EMERGENCY MEDICAL SERVICES (EMS) -- ADVISORY COMMITTEE (EMSAC)

DOCKET NO. 16-0101-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

A new chapter containing EMS education requirements is being promulgated (IDAPA 16.01.05). As part of its responsibilities, EMSAC reviews educational curricula and standards. A citation to this new chapter is being added to the portion of the EMSAC rules that describes EMSAC responsibilities related to EMS education. In addition, the current EMS chapter (IDAPA 16.02.03) is being repealed and some requirements from that chapter (e.g., regarding advance “do not resuscitate” directives) are being moved into this chapter so that they remain in effect.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 37 through 40](#).

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Bruce Cheeseman at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

Tuesday, August 11, 2015 - 10:00 a.m. MDT

2224 East Old Penitentiary Road
Boise, ID 83712

PARTICIPATION BY WEBINAR
(for those who are unable to attend the hearing)

To join the webinar, go to:
<https://global.gotomeeting.com/join/553709749>

Use your microphone and speakers (VoIP) -- a headset is recommended. Or, call in using your telephone.

Dial: 1 (646) 749-3122
Access Code: 553-709-749

Audio PIN: Shown after joining the meeting using URL above
Meeting ID: 553-709-749

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

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

A new chapter containing EMS education requirements is being promulgated (IDAPA 16.01.05). As part of its responsibilities, EMSAC reviews educational curricula and standards. A citation to this new chapter needs to be added to the portion of the EMSAC rules that describes EMSAC responsibilities related to EMS education. In addition, the current EMS chapter (IDAPA 16.02.03) is being repealed and some requirements from that chapter (e.g., regarding advance “do not resuscitate” directives) need to be moved into this chapter so that they remain in effect.

The negotiated rulemaking meetings listed above will allow stakeholders to provide their input concerning the rules that are being revised, updated, and reorganized into this new EMS education chapter.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

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 three (3) times: in the March 4, 2015, Idaho Administrative Bulletin, [Vol. 15-3, pages 13-15](#); the April 1, 2015, Idaho Administrative Bulletin, [Vol. 15-4, pages 28-30](#); and the May 6, 2015, Idaho Administrative Bulletin, [Vol. 15-5, pages 53-54](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0101-1501

110. EMS ADVISORY COMMITTEE MEMBERSHIP.

The Statewide EMS Advisory Committee must include the following representatives: (3-29-12)

01. Idaho Transportation Department. One (1) representative recommended by the Idaho Transportation Department, Office of Highway Operations and Safety. (3-29-12)

02. American College of Emergency Physicians (ACEP). One (1) representative recommended by the Idaho Chapter of American College of Emergency Physicians (ACEP). (3-29-12)

03. American College of Surgeons. One (1) representative recommended by the Committee on Trauma of the Idaho Chapter of the American College of Surgeons. (3-29-12)

04. Idaho Board of Nursing. One (1) representative recommended by the Idaho Board of Nursing. (3-29-12)

05. Idaho Medical Association. One (1) representative recommended by the Idaho Medical Association. (3-29-12)

06. Idaho Hospital Association. One (1) representative recommended by the Idaho Hospital Association. (3-29-12)

07. Idaho Association of Counties. One (1) representative of local government recommended by the Idaho Association of Counties. (3-29-12)

08. Career Third Service EMS/Ambulance Service. One (1) representative of a Career Third Service EMS/Ambulance Service. (3-29-12)

09. Volunteer Third Service EMS/Ambulance Service. One (1) representative of a volunteer third service EMS/ambulance service. (3-29-12)

10. Third Service Nontransport EMS Service. One (1) representative of a third service nontransport EMS service. (3-29-12)

11. Idaho Fire Chiefs Association. One (1) representative of a fire department-based EMS/ambulance service recommended by the Idaho Fire Chiefs Association. (3-29-12)

12. **Fire Department-Based Nontransport EMS Service.** One (1) representative of a fire department-based nontransport EMS service. (3-29-12)
13. **Air Medical Service.** One (1) representative of an air medical service. (3-29-12)
14. **Emergency Medical Technician.** One (1) Emergency Medical Technician who represents the interests of Idaho personnel licensed at that level. (3-29-12)
15. **Advanced Emergency Medical Technician.** One (1) Advanced Emergency Medical Technician who represents the interests of Idaho personnel licensed at that level. (3-29-12)
16. **Paramedic.** One (1) paramedic who represents the interests of Idaho personnel licensed at that level. (3-29-12)
17. **Administrative County EMS Director.** One (1) representative who is an Administrative County EMS Director. (3-29-12)
18. **EMS Instructor.** One (1) EMS instructor who represents the interests of Idaho EMS educators and evaluators. (3-29-12)
19. **Consumer.** One (1) Idaho citizen with experience involving EMS; (3-29-12)
20. **Private EMS Ambulance Service.** One (1) representative of a private EMS ambulance service. (3-29-12)
21. **American Academy of Pediatrics.** One (1) pediatrician who represents the interests of children in the EMS system recommended by the Idaho Chapter of the American Academy of Pediatrics. (3-29-12)
22. **Pediatric Emergency Medicine Physician.** One (1) board-certified, or equivalent, Pediatric Emergency Medicine Physician. (3-29-12)
23. **Public Health District.** One (1) representative from one (1) of Idaho's seven (7) public health districts. ()

111. -- 119. (RESERVED)

120. **RESPONSIBILITIES OF THE EMS ADVISORY COMMITTEE.**
The EMS Advisory Committee will meet at least annually, or as needed, for the purposes of: (3-29-12)

01. ~~Reviewing~~ **Policies and Procedures.** Reviewing policies and procedures for provision of emergency medical services and recommending same to the EMS Bureau. ~~(3-29-12)~~ ()

02. ~~Establishing Standard Protocols for EMS Personnel to Respond to Advance~~ **Do Not Resuscitate (DNR) Directives.** ~~The protocols will be reviewed at least annually to determine if changes in protocol need to be made in order to reflect technological advances~~ Establishing a standard protocol for EMS personnel to respond to advance DNR directives. ~~(3-29-12)~~ ()

a. The protocol will be reviewed at least annually to determine if changes in protocol should be made to reflect technological advances. The EMSAC must notify the Department of any changes made to the protocols. ()

b. The Department will notify Idaho EMS personnel of the DNR protocol and any subsequent changes. ()

c. The legal requirements for advance DNR directives are provided under Title 39, Chapter 45, Idaho Code. ()

03. ~~Reviewing~~ Educational Curricula and Standards. Reviewing EMS education curricula, education standards, and examination processes described in IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements." and providing their recommendations ~~same~~ regarding EMS education and examination to the EMS Bureau. ~~(3-29-12)~~()

04. Personnel Licensing Policies and Standards. Making recommendations to the EMS Bureau regarding implementation of personnel licensing policy and standards. (3-29-12)

05. ~~Reviewing~~ Grant Applications. Reviewing grant applications and making recommendations for eligibility and awards for the dedicated grant funds program in accordance with IDAPA 16.02.04, "Rules Governing Emergency Medical Services Account III Grants," Section 300. ~~(3-29-12)~~()

06. Ambulance and Nontransport Services. Reviewing and making recommendations on the licensing of ambulance and of nontransport services in Idaho. (3-29-12)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.02 - EMERGENCY MEDICAL SERVICES (EMS) -- RULE DEFINITIONS

DOCKET NO. 16-0102-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

A new chapter for EMS education requirements was promulgated and updates were made to this chapter to align it with the new chapter and to other the existing EMS licensing chapters. A clarification of the term “prehospital” is being made to the original proposed text in Section 013.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 41 through 48](#).

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Bruce Cheeseman at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

Tuesday, August 11, 2015 - 10:00 a.m. MDT

2224 East Old Penitentiary Road
Boise, ID 83712

PARTICIPATION BY WEBINAR
(for those who are unable to attend the hearing)

To join the webinar, go to:
<https://global.gotomeeting.com/join/553709749>

Use your microphone and speakers (VoIP) -- a headset is recommended. Or, call in using your telephone.

Dial: 1 (646) 749-3122
Access Code: 553-709-749

Audio PIN: Shown after joining the meeting using URL above
Meeting ID: 553-709-749

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

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

A new chapter containing EMS education requirements is being promulgated. Updates are being made to this chapter to align it with the new EMS education chapter, to related changes being made in the existing EMS personnel licensing chapter, and to recent additions to EMS statutes.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

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 three (3) times: in the March 4, 2015, Idaho Administrative Bulletin, [Vol. 15-3, pages 13-15](#); the April 1, 2015, Idaho Administrative Bulletin, [Vol. 15-4, pages 28-30](#); and the May 6, 2015, Idaho Administrative Bulletin, [Vol. 15-5, pages 53-54](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

Italicized red text that is double underscored is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0102-1501

001. TITLE AND SCOPE.

01. **Title.** The title of these rules is IDAPA 16.01.02, “Emergency Medical Services (EMS) -- Rule Definitions.” (7-1-14)

02. **Scope.** These rules contain the definitions used throughout the Emergency Medical Services chapters of rules adopted by the Department. Those chapters include: (7-1-14)

a. IDAPA 16.01.01, “Emergency Medical Services (EMS) -- Advisory Committee (EMSAC);” (7-1-14)

b. IDAPA 16.01.03, “Emergency Medical Services (EMS) -- Agency Licensing Requirements”; (7-1-14)

c. IDAPA 16.01.05, “Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements”; ()

d. IDAPA 16.01.07, “Emergency Medical Services (EMS) -- Personnel Licensing Requirements”; and (7-1-14) ()

e. IDAPA 16.01.12, “Emergency Medical Services (EMS) -- Complaints, Investigations and Disciplinary Actions.”; and (7-1-14) ()

f. IDAPA 16.02.03, “Emergency Medical Services.” (7-1-14)

(BREAK IN CONTINUITY OF SECTIONS)

011. DEFINITIONS AND ABBREVIATIONS C THROUGH E.

For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: (7-1-14)

01. **Call Volume.** The number of requests for service that an agency either anticipated or responded to during a designated period of time. (7-1-14)

02. **Candidate.** Any individual who is requesting an EMS personnel license under Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, “Emergency Medical Services (EMS) - Personnel Licensing Requirements.” (7-1-14)

03. **Certificate of Eligibility.** Documentation that an individual is eligible for affiliation with an EMS

agency, having satisfied all requirements for an EMS Personnel Licensure except for affiliation, but is not licensed to practice. (7-1-14)

04. Certification. A credential issued ~~to by an individual by the Department~~ designated certification body for a specified period of time indicating that minimum standards have been met. (7-1-14)()

05. Certified EMS Instructor. An individual approved by the Department, who has met the requirements in IDAPA 16.021.035, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements," to provide EMS education and training. (7-1-14)()

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

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

068. Compensated Volunteer. An individual who performs a service without promise, expectation, or receipt of compensation other than payment of expenses, reasonable benefits or a nominal fee to perform such services. This individual cannot be a part-time or full-time employee of the same organization performing the same services as a volunteer and employee. (7-1-14)

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

10. Consolidated Emergency Communications System. Facilities, equipment, and dispatching services directly related to establishing, maintaining, or enhancing a 911 emergency communications service defined in Section 31-4802, Idaho Code. ()

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

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

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

~~0714.~~ **Credentialing.** The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice. (7-1-14)

~~0815.~~ **Credentialed EMS Personnel.** Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. (7-1-14)

~~0916.~~ **Critical Care.** The treatment of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer. Interventions provided by Paramedics are governed by the scope of practice defined in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (7-1-14)

~~107.~~ **Critical Care Agency.** An ambulance or air medical EMS agency that advertises and provides all of the skills and interventions defined as critical care in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (7-1-14)

~~148.~~ **Department.** The Idaho Department of Health and Welfare. (7-1-14)

- 129. Director.** The Director of the Idaho Department of Health and Welfare or his designee. (7-1-14)
- 130. Division.** The Division of Public Health, Idaho Department of Health and Welfare. (7-1-14)
- 141. Emergency.** A medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. (7-1-14)
- 152. Emergency Medical Care.** The care provided to a person suffering from a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. (7-1-14)
- 163. Emergency Medical Responder (EMR).** An EMR is a person who: (7-1-14)
- a.** Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements"; (7-1-14)
 - b.** Is licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code; (7-1-14)
 - c.** Carries out the practice of emergency medical care within the scope of practice for EMR determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission"; and (7-1-14)
 - d.** Practices under the supervision of a physician licensed in Idaho. (7-1-14)
- 174. Emergency Medical Services (EMS).** Under Section 56-1012(12), Idaho Code, emergency medical services or EMS is aid rendered by an individual or group of individuals who do the following: (4-11-15)
- a.** Respond to a perceived need for medical care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury; (4-11-15)
 - b.** Are prepared to provide interventions that are within the scope of practice as defined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission"; (4-11-15)
 - c.** Use an alerting mechanism to initiate a response to requests for medical care; and (4-11-15)
 - d.** Offer, advertise, or attempt to respond as described in Section 56-1012(12), (a) through (c), Idaho Code. (4-11-15)
 - e.** Aid rendered by a ski patroller, as described in Section 54-1804(1)(h), Idaho Code, is not EMS. (4-11-15)
- 185. Emergency Medical Services Advisory Committee (EMSAC).** The statewide advisory board of the Department as described in IDAPA 16.01.01, "Emergency Medical Services (EMS) - Advisory Committee (EMSAC)." EMSAC members are appointed by the Director of the Idaho Department of Health and Welfare to provide counsel to the Department on administering the EMS Act. (7-1-14)
- 196. EMS Agency.** Any organization licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements," that operates an air medical service, ambulance service, or non-transport service. (7-1-14)
- 207. EMS Bureau.** The Bureau of Emergency Medical Services (EMS) & Preparedness of the Idaho

Department of Health and Welfare. (7-1-14)

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

29. EMS Education Program Director. The individual responsible for an EMS educational program or programs. ()

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

31. EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. (7-1-14)

32. EMS Physician Commission (EMSPC). The Idaho Emergency Medical Services Physician Commission created under Section 56-1013A, Idaho Code, also referred to as “the Commission.” (7-1-14)

33. Emergency Medical Technician (EMT). An EMT is a person who: (7-1-14)

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, “Emergency Medical Services - Personnel Licensing Requirements”; (7-1-14)

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (7-1-14)

c. Carries out the practice of emergency medical care within the scope of practice for EMT determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission”; and (7-1-14)

d. Practices under the supervision of a physician licensed in Idaho. (7-1-14)

34. Emergency Scene. Any setting outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. (7-1-14)

012. DEFINITIONS AND ABBREVIATIONS F THROUGH N.

For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: (7-1-14)

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

02. Full-Time Paid Personnel. Personnel who perform a service with the promise, expectation, or receipt of compensation for performing such services. Full-time personnel differ from part-time personnel in that full-time personnel work a more regular schedule and typically work more than thirty-five (35) hours per week. (7-1-14)

03. Glasgow Coma Score (GCS). A scale used to determine a patient's level of consciousness. It is a rating from three (3) to fifteen (15) of the patient's ability to open his eyes, respond verbally, and move normally. The GCS is used primarily during the examination of patients with trauma or stroke. (7-1-14)

04. Ground Transport Time. The total elapsed time calculated from departure of the ambulance from the scene to arrival of the ambulance at the patient destination. (7-1-14)

05. Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. (7-1-14)

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

07. Instructor Certification. A credential issued to an individual by the Department for a specified

period of time indicating that minimum standards for providing EMS instruction under IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements," have been met. ()

~~058.~~ **Intermediate Life Support (ILS).** The provision of medical care, medication administration, and treatment with medical devices which correspond to the knowledge and skill objectives in the AEMT curriculum currently approved by the State Health Officer and within the scope of practice defined in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," by persons licensed as AEMTs by the Department. (7-1-14)

~~069.~~ **Investigation.** Research of the facts concerning a complaint or issue of non-compliance which may include performing or obtaining interviews, inspections, document review, detailed subject history, phone calls, witness statements, other evidence, and collaboration with other jurisdictions of authority. (7-1-14)

~~0710.~~ **License.** A document issued by the Department to an agency or individual authorizing specified activities and conditions as described under Sections 56-1011 through 56-1023, Idaho Code. (7-1-14)

~~0811.~~ **Licensed Personnel.** Those individuals who are licensed by the Department as Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics. (7-1-14)

~~0912.~~ **Licensed Professional Nurse.** A person who meets all the applicable requirements and is licensed to practice as a Licensed Professional Nurse under Sections 54-1401 through 54-1418, Idaho Code. (7-1-14)

~~103.~~ **Local Incident Management System.** The local system of interagency communications, command, and control established to manage emergencies or demonstrate compliance with the National Incident Management System. (7-1-14)

~~114.~~ **Medical Supervision Plan.** The written document describing the provisions for medical supervision of licensed EMS personnel. (7-1-14)

~~125.~~ **National Registry of Emergency Medical Technicians (NREMT).** An independent, non-governmental, not for profit organization which prepares validated examinations for the state's use in evaluating candidates for licensure. (7-1-14)

~~136.~~ **Non-transport Agency.** An agency licensed by the Department, operated with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but not intended to be the service that will actually transport sick or injured persons. (7-1-14)

~~147.~~ **Non-transport Vehicle.** Any vehicle operated by an agency with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but not intended as the vehicle that will actually transport sick or injured persons. (7-1-14)

~~158.~~ **Nurse Practitioner.** An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-14)

013. DEFINITIONS AND ABBREVIATIONS O THROUGH Z.

For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: (7-1-14)

~~01.~~ **Optional Module.** Optional modules (OMs) are skills identified by the EMS Physician Commission that exceed the floor level Scope of Practice for EMS personnel and may be adopted by the agency medical director. ()

~~042.~~ **Out-of-Hospital.** Any setting outside of a hospital, including inter-facility transfers, in which the provision of EMS may take place. (7-1-14)

- 023.** **Paramedic.** A paramedic is a person who: (7-1-14)
- a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements"; (7-1-14)
 - b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (7-1-14)
 - c. Carries out the practice of emergency medical care within the scope of practice for paramedic determined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission"; and (7-1-14)
 - d. Practices under the supervision of a physician licensed in Idaho. (7-1-14)
- 04.** **Paramedicine.** Providing emergency care to sick and injured patients at the advanced life support (ALS) level with defined roles and responsibilities to be credentialed at the Paramedic level. ()
- 035.** **Part-Time Paid Personnel.** Personnel who perform a service with the promise, expectation, or receipt of compensation for performing such services. Part-time personnel differ from the full-time personnel in that the part-time personnel typically work an irregular schedule and work less than thirty-five (35) hours per week. (7-1-14)
- 046.** **Patient.** A sick, injured, incapacitated, or helpless person who is under medical care or treatment. (7-1-14)
- 057.** **Patient Assessment.** The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. (7-1-14)
- 068.** **Patient Care.** The performance of acts or procedures under emergency conditions in responding to a perceived individual need for immediate care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury. (7-1-14)
- 079.** **Patient Movement.** The relatively short distance transportation of a patient from an off-highway emergency scene to a rendezvous with an ambulance or air ambulance. (7-1-14)
- 0810.** **Patient Transport.** The transportation of a patient by ambulance or air ambulance from a rendezvous or emergency scene to a medical care facility. (7-1-14)
- 0911.** **Physician.** A person who holds a current active license in accordance with Section 54-1803, Idaho Code, issued by the State Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restrictions upon, or actions taken against, his license. (7-1-14)
- 102.** **Physician Assistant.** A person who meets all the applicable requirements and is licensed to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code. (7-1-14)
- 143.** **Planned Deployment.** The deliberate, planned placement of EMS personnel outside of an affiliating agency's deployment model declared on the application under which the agency is currently licensed. (7-1-14)
- 124.** **Prehospital.** Any setting outside of a where emergency medical care is provided prior to or during transport to a hospital, with the exception of transfers, in which the provision of EMS may take place. (7-1-14) ()
- 15.** **Psychomotor Exam.** Practical demonstration of skills learned during an EMS education course. ()
- 136.** **Response Time.** The total time elapsed from when the agency receives a call for service to when the agency arrives and is available at the scene. (7-1-14)

~~14~~**7.** **Skills Proficiency.** The process overseen by an EMS agency medical director to verify competency in psychomotor skills. (7-1-14)

~~15~~**8.** **State Health Officer.** The Administrator of the Division of Public Health. (7-1-14)

~~19.~~ **Summative Evaluation.** End of topic or end of course evaluation that covers both didactic and practical skills application. ()

~~46~~**20.** **Supervision.** The medical direction by a licensed physician of activities provided by licensed personnel affiliated with a licensed ambulance, air medical, or non-transport service, including: (7-1-14)

a. Establishing standing orders and protocols; (7-1-14)

b. Reviewing performance of licensed personnel; (7-1-14)

c. Providing instructions for patient care via radio or telephone; and (7-1-14)

d. Other oversight. (7-1-14)

~~47~~**21.** **Third Service.** A public EMS agency that is neither law-enforcement nor fire-department based. (7-1-14)

~~48~~**22.** **Transfer.** The transportation of a patient from one (1) medical care facility to another. (7-1-14)

~~49~~**23.** **Uncompensated Volunteer.** An individual who performs a service without promise, expectation, or receipt of any compensation for the services rendered. An uncompensated volunteer cannot be a part-time or full-time employee of the same organization performing the same services as a volunteer and employee. (7-1-14)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.03 - EMERGENCY MEDICAL SERVICES (EMS) -- AGENCY LICENSING REQUIREMENTS

DOCKET NO. 16-0103-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

The EMS Agency Licensing rules are being aligned with a new chapter of rules that provide the education, instructor, and examination standards an individual must meet to be a licensed EMS provider in Idaho. Changes are being made in the pending rule to clarify ambulance-based clinicians for an agency transfer declaration operation. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 49 through 56](#).

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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Bruce Cheeseman at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

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

Tuesday, August 11, 2015 - 10:00 a.m. MDT

**2224 East Old Penitentiary Road
Boise, ID 83712**

**PARTICIPATION BY WEBINAR
(for those who are unable to attend the hearing)**

To join the webinar, go to:
<https://global.gotomeeting.com/join/553709749>

Use your microphone and speakers (VoIP) -- a headset is recommended. Or, call in using your telephone.

Dial: 1 (646) 749-3122
Access Code: 553-709-749

Audio PIN: Shown after joining the meeting using URL above
Meeting ID: 553-709-749

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

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

The EMS Agency Licensing rules are being amended to align with a new chapter of rules being written that provide the education, instructor, and examination standards an individual must meet to be a licensed EMS provider in Idaho. These rules also include additions and references to rules from the repeal of IDAPA 16.02.03, "Emergency Medical Services," and the new chapter in IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructors, and Examination Requirements."

Updates have been made for Operational Declarations for prehospital, community health EMS, and air medical support. Agency records that were in the repealed chapter have also been added into these rules.

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

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was held under the Personnel Licensing and the Education chapters, but not specifically for EMS agencies. The changes in this rule are being made to align with the new chapter and add requirements from the repealed chapter.

INCORPORATION BY REFERENCE: There are no documents incorporated in this rulemaking.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

Italicized red text that is double underscored is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0103-1501

204. GROUND EMS AGENCY -- OPERATIONAL DECLARATIONS.

An agency providing ground services is licensed with one (1) or more of the following operational declarations depending on the services that the agency advertises or offers. (7-1-14)

01. Prehospital. The prehospital operational declaration is available to an agency ~~with~~ that: ()

a. Has primary responsibility for responding to calls for EMS within their designated geographic coverage area- and (7-1-14)()

b. Is dispatched to prehospital emergency medical calls by a consolidated emergency communications system. ()

02. Prehospital Support. The prehospital support operational declaration is available to an agency that: ()

a. ~~P~~Provides support under agreement to a prehospital agency having primary responsibility for responding to calls for EMS within a designated geographic coverage area- and (7-1-14)()

b. Is dispatched to prehospital emergency medical calls by a consolidated emergency communications system. ()

03. Community Health EMS. The community health EMS operational declaration is available to an agency with a prehospital operational declaration or prehospital support operational declaration that provides personnel and equipment for medical assessment and treatment at a non-emergency scene or at the direction of a physician or independent practitioner. (7-1-14)()

04. Transfer. The transfer operational declaration is available to an ambulance agency that provides EMS personnel and equipment for the transportation of patients from one (1) medical care facility in their designated geographic coverage area to another. An agency with this operational declaration must declare which sending facilities it routinely responds to if requested. (7-1-14)

05. Standby. The standby operational declaration is available to an agency that provides EMS personnel and equipment to be staged at prearranged events within their designated geographic coverage area. (7-1-14)

06. Non-Public. The non-public operational declaration is available to an agency that provides EMS personnel and equipment intended to treat patients who are employed or contracted by the license holder. An agency with a non-public operational declaration is not intended to treat members of the general public. A non-public agency must maintain written plans for patient treatment and transportation. (7-1-14)

205. AIR MEDICAL AGENCY -- OPERATIONAL DECLARATIONS.

An agency providing air medical services is licensed with one (1) or ~~both~~ more of the following operational declarations depending on the services that the agency advertises or offers. Service levels, geographic coverage areas, and resources may differ between the operational declarations under which an agency is licensed. ~~(7-1-14)~~ ()

01. Air Medical Transport. The air medical transport operational declaration is available to an air medical agency that provides transportation of patients by air ambulance from a rendezvous or emergency scene to a medical care facility within its designated geographic coverage area. (7-1-14)

02. Air Medical Transfer. The air medical transfer operational declaration is available to an Air Medical I agency that provides transportation of patients by air ambulance from one (1) medical care facility in its designated geographic coverage area to another. An agency with this operational declaration must declare which sending facilities it routinely responds to if requested. (7-1-14)

03. Air Medical Support. The air medical support operational declaration is available to an air medical agency that provides transportation of patients from an emergency scene to a rendezvous with a ground or air medical transport agency within its designated response area. ()

(BREAK IN CONTINUITY OF SECTIONS)

300. EMS AGENCY -- GENERAL PERSONNEL REQUIREMENTS.

Personnel must be licensed according to IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." (7-1-14)

01. Personnel Requirements for EMS Agency Licensure. Each agency must ensure availability of affiliated personnel licensed and credentialed at or above the ~~agency's highest~~ clinical level for the entire anticipated call volume for each of the agency's operational declarations. ~~(7-1-14)~~ ()

02. Personnel Requirements for an Agency Utilizing Emergency Medical Dispatch. An agency dispatched by ~~a public safety answering point (PSAP)~~ a consolidated emergency communications system that uses an emergency medical dispatch (EMD) process to determine the clinical needs of the patient must ensure availability of personnel licensed and credentialed at clinical levels appropriate to the anticipated call volume for each of the clinical levels the agency provides. ~~(7-1-14)~~ ()

03. Personnel Requirements for Prehospital ALS. A licensed Paramedic must be present whenever prehospital, prehospital support, or air medical transport ALS services are provided. (7-1-14)

(BREAK IN CONTINUITY OF SECTIONS)

305. AMBULANCE-BASED CLINICIANS -- PERSONNEL REQUIREMENTS.

01. Ambulance-Based Clinician Certified by Department. An EMS agency that advertises or provides out-of-hospital patient care by affiliating and utilizing a currently licensed professional nurse, advanced practice professional nurse, or physician assistant, as defined in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," must ensure that those individuals maintain a current ambulance-based clinician certificate issued by the Department. See Section 306 of these rules for exceptions to this requirement. (7-1-14)

02. Obtaining an Ambulance-Based Clinician Certificate. An agency, on behalf of an individual who desires an ambulance-based clinician certificate, must provide the following information on the Department's application for a certificate: (7-1-14)

a. Documentation that the individual holds a current, unrestricted license to practice issued by the Board of Medicine or Board of Nursing; and (7-1-14)

b. Documentation that the individual has successfully completed an ambulance-based clinician

course; or (7-1-14)

- c. Documentation that the individual has successfully completed an EMT course. (7-1-14)

03. Maintaining an Ambulance-Based Clinician Certificate. An ambulance-based clinician certificate is valid for as long as the holder of the certificate is continuously licensed by his respective licensing board. (7-1-14)

04. Revocation of an Ambulance-Based Clinician Certificate. The Department may revoke an ambulance-based clinician certificate based on the procedures for administrative license actions described in IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." (7-1-14)

~~**05. Currently Practicing Ambulance-Based Clinicians.** In order to continue the utilization of an ambulance-based clinician, an EMS agency must ensure that its currently practicing clinicians have obtained the Department issued ambulance-based clinician certificate by July 1, 2015. (7-1-14)~~

~~**06. Licensed Personnel Requirements and Ambulance-Based Clinicians.** An EMR/BLS, EMT/BLS, or AEMT/ILS agency may use ambulance-based clinicians to meet the licensed personnel requirements for agency licensure. An ALS agency, licensed with an ALS transfer declaration described in Section 204.04 of these rules, may use ambulance-based clinicians to meet the licensed personnel requirements for the transfer declaration. (7-1-14)()~~

~~**07. Agency Responsibilities for Ambulance-Based Clinicians.** The agency must verify that each ambulance-based clinician possess a current ambulance-based clinician certificate issued by the Department. The agency must ensure that any ambulance-based clinician meets additional requirements of the corresponding licensing board. (7-1-14)~~

(BREAK IN CONTINUITY OF SECTIONS)

535. EMS AGENCY -- RECORDS, DATA COLLECTION, AND SUBMISSION REQUIREMENTS. Each EMS agency must comply with the following records, data collection, and submission requirements required in IDAPA 16.02.03, "Emergency Medical Services," Section 435. (7-1-14)()

01. Records to be Maintained by Ambulance and Air Medical Agencies. Each EMS ambulance and air medical agency must maintain records of each ambulance and air ambulance response and submit them to the EMS Bureau at least quarterly in a form approved by the EMS Bureau. These records must include at least the following information: ()

- a. Name of ambulance service: ()
- b. Date of response: ()
- c. Time call received: ()
- d. Time en route to scene: ()
- e. Time arrival at scene: ()
- f. Time service departed scene: ()
- g. Time arrival at hospital: ()
- h. Location of incident: ()
- i. Description of illness/injury: ()

- i. Description of patient management: ()
- k. Patient destination: ()
- l. Ambulance unit identification: ()
- m. Identification and licensure level of each ambulance crew member on the response; and ()
- n. Response outcome. ()

02. Records to Be Maintained by Non-Transport Agencies. Each non-transport agency must maintain records of each EMS response in a form approved by the EMS Bureau. Each applicant non-transport services agency who submits an application to the EMS Bureau after July 1, 2009, must submit records of each EMS response to the EMS Bureau at least quarterly in a form approved by the EMS Bureau. These records must include at least the following information: ()

- a. Identification of non-transport service: ()
- b. Date of response: ()
- c. Time call received: ()
- d. Time en route to scene: ()
- e. Time arrival at scene: ()
- f. Time service departed scene: ()
- g. Location of incident: ()
- h. Description of illness/injury: ()
- i. Description of patient management: ()
- j. Patient destination: ()
- k. Identification and licensure level of non-transport service personnel on response; and ()
- l. Response outcome. ()

(BREAK IN CONTINUITY OF SECTIONS)

700. EMS AGENCY -- CRITERIA TO REQUEST AN AIR MEDICAL RESPONSE.

Each ground EMS agency must establish written criteria for the agency's licensed EMS personnel that provides decision-making guidance for requesting an air medical response to an emergency scene. This criteria must be approved by the agency's medical director. The following conditions must be included in the criteria: (7-1-14)

01. Clinical Conditions. Each licensed EMS agency must develop written criteria based on best medical practice principles for requesting an air medical response for the following clinical conditions: (7-1-14)

- a.** The patient has a penetrating or crush injury to head, neck, chest, abdomen, or pelvis; (7-1-14)
- b.** Neurological presentation suggestive of spinal cord injury; (7-1-14)

- c. Evidence of a skull fracture (depressed, open, or basilar) as detected visually or by palpation; (7-1-14)
- d. Fracture or dislocation with absent distal pulse; (7-1-14)
- e. A glasgow coma score of ten (10) or less; (7-1-14)
- f. Unstable vital signs with evidence of shock; (7-1-14)
- g. Cardiac arrest; (7-1-14)
- h. Respiratory arrest; (7-1-14)
- i. Respiratory distress; (7-1-14)
- j. Upper airway compromise; (7-1-14)
- k. Anaphylaxis; (7-1-14)
- l. Near drowning; (7-1-14)
- m. Changes in level of consciousness; (7-1-14)
- n. Amputation of an extremity; and (7-1-14)
- o. Burns greater than twenty percent (20%) of body surface or with suspected airway compromise. (7-1-14)

02. Complications to Clinical Conditions. Each licensed EMS agency must develop a written policy that provides guidance for requesting an air medical response when there are complicating conditions associated with the clinical conditions listed in Subsection 700.01 of this rule. The complicating conditions must include the following: (7-1-14)

- a. Extremes of age; (7-1-14)
- b. Pregnancy; and (7-1-14)
- c. Patient "do not resuscitate" status ~~as described in IDAPA 16.02.03, "Emergency Medical Services," Section 400.~~ (7-1-14) ()

03. Operational Conditions for Air Medical Response. Each licensed EMS agency must have written criteria to provide guidance to the licensed EMS personnel for the following operational conditions: (7-1-14)

- a. Availability of local hospitals and regional medical centers; (7-1-14)
- b. Air medical response to the scene and transport to an appropriate hospital will be significantly shorter than ground transport time; (7-1-14)
- c. Access to time sensitive medical interventions such as percutaneous coronary intervention, thrombolytic administration for stroke, or cardiac care; (7-1-14)
- d. When the patient's clinical condition indicates the need for advanced life support and air medical is the most readily available access to advanced life support capabilities; (7-1-14)
- e. As an additional resource for a multiple patient incident; (7-1-14)
- f. Remote location of the patient; and (7-1-14)

- g. Local destination protocols. (7-1-14)

(BREAK IN CONTINUITY OF SECTIONS)

816. AMBULANCE EMS AGENCY -- EQUIPMENT TO BE INSPECTED.

Each ambulance EMS agency must have the minimum equipment specified in the "Minimum Equipment Standards for Licensed EMS Services," incorporated by reference in Section 004 of these rules. (7-1-14)

01. Medical Care Supplies. Each ambulance must be equipped with medical care supplies and devices as specified in the agency minimum equipment standards unless Subsection 816.02 or 816.03 of this rule applies. (7-1-14)

02. ~~Public Safety Answering Point Dispatch~~ Consolidated Emergency Communications System.
An agency dispatched by ~~a public safety answering point (PSAP)~~ a consolidated emergency communications system that uses an emergency medical dispatch (EMD) process to determine the clinical needs of the patient must ensure the availability of medical care supplies and devices as specified in the agency minimum equipment standards that are appropriate for each response. (7-1-14)()

03. Agency Transferring Patients. An agency transferring patients from one (1) medical care facility included in their designated geographic coverage area to another will be equipped with medical care supplies and devices appropriate for the patient identified by the sending facility. (7-1-14)

(BREAK IN CONTINUITY OF SECTIONS)

969. COMPLETE AND COMPLIANT RENEWAL APPLICATION.

When a renewal application is found to be complete and in compliance, the Department will notify the agency and ~~provide a list of not less than five (5) available dates and times within a thirty (30) day period in which to~~ schedule the required renewal inspection at a time and date that allows efficient use of Department resources and meets the needs of the agency. (7-1-14)()

970. TIMEFRAME FOR RENEWAL INSPECTIONS.

Each agency must successfully complete an annual inspection ~~within the~~ no earlier than sixty (60) days and no later than thirty (30) days ~~period described in Sections 800 through 809 of these rules in order to obtain a renewed license prior to the expiration date of the current license.~~ (7-1-14)()

(BREAK IN CONTINUITY OF SECTIONS)

~~982. -- 989.~~ (RESERVED)

~~990. TRANSITION TO THE LICENSURE MODELS DESCRIBED IN THIS CHAPTER OF RULES.~~

~~01. Timeframe to Transition to the New Licensing Model. Each EMS agency licensed by the Department prior to July 1, 2014, will transition to a licensing model described in these rules at the expiration of its current agency license. A currently licensed agency must submit a licensure transition application, provided by the Department, in order to renew its agency license.~~ (7-1-14)

~~02. Review Process of Transition Applications. Each licensure transition application submitted by a currently licensed agency is subject to the same Department application evaluation process described in Section 966 of these rules.~~ (7-1-14)

~~991-999.~~ -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.05 - EMERGENCY MEDICAL SERVICES (EMS) -- EDUCATION, INSTRUCTOR, AND EXAMINATION REQUIREMENTS

DOCKET NO. 16-0105-1501 (NEW CHAPTER)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

This new chapter of rules implements and provides updated initial education, instructor, and examination requirements to meet the ever-changing technology and techniques used to protect the health and safety of the public in the provision of emergency medical services (EMS). This new chapter replaces the education requirements currently found in IDAPA 16.02.03, "Emergency Medical Services."

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 57 through 69](#).

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Bruce Cheeseman at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

Tuesday, August 11, 2015 - 10:00 a.m. MDT

**2224 East Old Penitentiary Road
Boise, ID 83712**

**PARTICIPATION BY WEBINAR
(for those who are unable to attend the hearing)**

To join the webinar, go to:
<https://global.gotomeeting.com/join/553709749>

Use your microphone and speakers (VoIP) -- a headset is recommended. Or, call in using your telephone.

Dial: 1 (646) 749-3122
Access Code: 553-709-749

Audio PIN: Shown after joining the meeting using URL above
Meeting ID: 553-709-749

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 new chapter of rules is being written to implement and provide updated initial education, instructor, and examination requirements to meet the ever-changing technology and techniques used to protect the health and safety of the public in the provision of emergency medical services (EMS). This new chapter will replace the education requirements currently found in IDAPA 16.02.03, "Emergency Medical Services."

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

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 three (3) times: in the March 4, 2015, Idaho Administrative Bulletin, **Vol. 15-3, pages 13-15**; the April 1, 2015, Idaho Administrative Bulletin, **Vol. 15-4, pages 28-30**; and the May 6, 2015, Idaho Administrative Bulletin, **Vol. 15-5, pages 53-54**.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following documents are being incorporated by reference into these rules. These documents are not being reprinted in this chapter of rules due to their length and format and because of the cost for republication. Further, incorporation into this rule gives the

manuals the force and effect of law.

1. Idaho EMS Education Standards, edition 2016-1.
2. Idaho Bureau of EMS and Preparedness EMS Education Equipment List, edition 2016-1.
3. Idaho EMS Bureau Vehicle Extrication Awareness Instructor Guidelines, edition 2016-1.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0105-1501

IDAPA 16
TITLE 01
CHAPTER 05

**16.01.05 - EMERGENCY MEDICAL SERVICES (EMS) -- EDUCATION, INSTRUCTOR,
AND EXAMINATION REQUIREMENTS**

000. LEGAL AUTHORITY.

The Idaho Board of Health and Welfare is authorized under Section 56-1023, Idaho Code, to adopt rules and standards concerning the administration of the Idaho Emergency Medical Services Act, Sections 56-1011 through 56-1023, Idaho Code. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical service program. ()

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements." ()

02. Scope. These rules include criteria and requirements for education programs conducting initial and optional module EMS education, certification of instructors, certification examinations, and optional module examinations. Continuing education requirements can be found in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ()

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, the Department may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. ()

003. ADMINISTRATIVE APPEALS.

Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing

Contested Case Proceedings and Declaratory Rulings.” ()

004. INCORPORATION BY REFERENCE.

The Department has incorporated by reference the following documents: ()

01. Idaho EMS Education Standards, edition 2016-1. The Department has adopted the Idaho EMS Education Standards, edition 2016-1, and hereby incorporates these standards by reference. Copies may be obtained from the Department described in Section 005 of these rules, or online at: <http://www.IdahoEMS.org>. ()

02. Idaho Bureau of EMS and Preparedness EMS Education Equipment List, edition 2016-1. The Department has adopted the Idaho Bureau of EMS and Preparedness EMS Education Equipment List, edition 2016-1, and hereby incorporates these standards by reference. Copies may be obtained from the Department described in Section 005 of these rules, or online at: <http://www.IdahoEMS.org>. ()

03. Idaho EMS Bureau Vehicle Extrication Awareness Instructor Guidelines, edition 2016-1. The Department has adopted the Idaho EMS Bureau Vehicle Extrication Awareness Instructor Guidelines, edition 2016-1, and hereby incorporates these standards by reference. Copies may be obtained from the Department described in Section 005 of these rules, or online at: <http://www.IdahoEMS.org>. ()

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. ()

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. ()

03. Street Address. ()

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

b. The Bureau of Emergency Medical Services and Preparedness is located at 2224 East Old Penitentiary Road, Boise, ID 83712-8249. ()

04. Telephone. ()

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

b. The telephone number for the Bureau of Emergency Medical Services and Preparedness is (208) 334-4000. The toll-free, phone number is 1-877-554-3367. ()

05. Internet Websites. ()

a. The Department’s internet website is found at <http://www.healthandwelfare.idaho.gov>. ()

b. The Bureau of Emergency Medical Services and Preparedness internet website is found at <http://www.idahoems.org>. ()

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

01. Confidentiality of Records. Any information about an individual covered by these rules and contained in the Department’s records must comply with IDAPA 16.05.01, “Use and Disclosure of Department Records.” ()

02. Public Records Act. The Department will comply with Title 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ()

007. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

Certified EMS instructors must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," to include: ()

01. Initial Instructor Certification. Individuals seeking initial instructor certification must have successfully passed a criminal history and background check under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." ()

02. Reinstatement of Instructor Certification. Individuals requesting reinstatement of instructor certification must have successfully passed a criminal history and background check under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under IDAPA 16.05.06 will result in denial of reinstatement of certification. ()

03. Additional Criminal History and Background Check. The Department may require an updated or additional criminal history and background check at any time, without expense to the candidate, if there is cause to believe new or additional information will be disclosed. ()

010. DEFINITIONS.

For the purposes of this chapter, the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions" apply. ()

011. -- 074. (RESERVED)

075. INVESTIGATION OF COMPLAINTS FOR EMS EDUCATION PROGRAM AND PERSONNEL VIOLATIONS.

Investigation of complaints and disciplinary actions for EMS education program and personnel are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." ()

076. ADMINISTRATIVE ACTION IMPOSED FOR EMS INSTRUCTOR CERTIFICATION.

Any EMS instructor certificate may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative actions on an instructor certificate, imposed by the EMS Bureau for any action, conduct, or failure to act which is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." ()

077. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS EDUCATION PROGRAM AND EXAM PERSONNEL.

All personnel associated with a EMS education program or exam must adhere to the following standards: ()

01. Professional Conduct. EMS education program and exam personnel must uphold the dignity and honor of the profession and abide by all federal, state, and local laws and statutes. They must ensure just and equitable treatment for all members of the profession in the exercise of academic freedom, professional rights, and responsibilities while following generally recognized professional principles. ()

02. Personal Relationships. EMS education program and exam personnel must maintain a professional relationship with all students, both inside and outside the physical and virtual classroom. They must avoid conflicts of interest when accepting gifts, gratuities, favors, and additional compensation from students, colleagues, parents, patrons, or business personnel. ()

03. Professional Integrity. EMS education program and exam personnel must exemplify honesty and

integrity in the course of professional practice. They must refrain from the possession, use, or abuse of alcohol or illegal drugs while they are involved in the instruction of students. They must comply with state and federal laws and program policies relating to the confidentiality of student records, unless disclosure is required or permitted by law.

()

04. Respectful Behavior. EMS education program and exam personnel must behave in a respectful and appropriate manner when dealing with students, colleagues, parents, patrons, and business or Department personnel, ensuring that they are always aware of their intended audience.

()

078. -- 099. (RESERVED)

EMS EDUCATION PROGRAMS
(Sections 100 - 199)

100. GENERAL REQUIREMENTS FOR EMS EDUCATION PROGRAMS.

EMS education programs must meet all requirements in these rules. A program may be approved by the Department if all requirements are met. Each program must be approved and in good standing in order for graduates of courses provided by a program to qualify for access to an Idaho EMS certification examination.

()

101. INSPECTION OF EMS EDUCATION PROGRAMS.

Representatives of the Department are authorized to enter an EMS education facility at reasonable times for the purpose of assuring that an EMS education program meets the provisions of these rules.

()

102. EMS EDUCATION STANDARDS.

01. Initial Education. Curriculum utilized for initial education must be based upon the Idaho EMS Education Standards incorporated under Section 004 of these rules.

()

02. Optional Module Education. Curriculum utilized for optional module education must be based upon the Idaho EMS Education Standards incorporated under Section 004 of these rules for the higher level scope of practice in which the skills, knowledge, and competency exist in the floor of the scope of practice.

()

103. EMS EDUCATION PROGRAM ELIGIBILITY.

The following entities are eligible for approval as an EMS Education Program:

()

01. EMS Agency. A licensed Idaho EMS agency, or applicant for agency licensure, that has met all of the agency licensure requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," with the exception of the personnel requirements in the case of an applicant agency.

()

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

()

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

()

04. Hospital. An Idaho hospital as defined in IDAPA 16.03.14, "Rules and Minimum Standards for Hospitals in Idaho."

()

104. EMS EDUCATION PROGRAM APPROVAL REQUIREMENTS.

The following requirements must be met in order to be approved as an EMS Education Program:

()

01. All Programs. All EMS educational programs must:

()

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

()

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

()

- c. Utilize personnel to fill the roles as defined in Section 300; ()
- d. Provide sufficient quantities of supplies and equipment in good working order based on the curriculum and the minimum equipment list; and ()
- e. Have successfully completed a program review within the last three (3) years. ()

02. Paramedicine Programs. Programs teaching paramedicine must be accredited by, or have a Letter of Review (LoR) from, the Committee on Accreditation of Educational Programs for the EMS Professions (CoAEMSP). A representative of the Department may attend the CoAEMSP site visit. Documentation of official correspondence between CoAEMSP and the program must be provided to the Department within thirty (30) days. ()

105. EMS EDUCATION PROGRAM ACCOUNTABILITY.

The Department will hold each EMS Education Program to the standards and requirements in these rules and the declarations made by the program on their most recent approved application. ()

106. EMS EDUCATION PROGRAM ADMINISTRATION.

- 01. General.** Each EMS Education Program must: ()
 - a. Register and maintain program information with the Department and the certification agency. ()
 - b. Respond to all program-specific Department inquiries within fifteen (15) days; ()
 - c. Submit supporting documentation requested during an audit to the Department within twenty-one (21) days of the request; ()
 - d. Ensure that all program personnel are familiar with and conduct business according to these rules; and ()
 - e. Notify the Department within fifteen (15) days of any sanction taken against an instructor that affects his ability to teach for the program. ()

02. Policies and Procedures. The EMS Education Program must provide students with their policies and procedures for the following: ()

- a. Program-specific student enrollment eligibility requirements; ()
- b. Receipt and resolution of complaints, to include the Bureau's complaint process; ()
- c. Process for students who do not show adequate progress; and ()
- d. Program-specific requirements for successful completion of the course. ()

107. EMS EDUCATION PROGRAM COURSE ADMINISTRATION.

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

- a. Deliver didactic education and psychomotor training that meets the objectives of the approved curriculum; ()
- b. Establish and maintain hospital/clinical and field/internship experience agreements to ensure student access in accordance with the Idaho EMS Education Standards; ()

- c. The majority of initial education must be taught by certified EMS instructors. ()

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

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

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

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

108. EMS EDUCATION PROGRAM COURSE DOCUMENTATION.

01. Records to be Submitted. Each EMS Education Program must submit the following documentation to the Department as described below and in the format provided by the Department: ()

a. Application for Course Registration Number (CRN) at least thirty (30) days prior to beginning a new course; ()

b. Course beginning record (roster) within ten (10) days after the course beginning date; ()

c. EMR and EMT Programs: Declare date and location of the formal summative evaluation within the (10) days immediately following the date the course begins; ()

d. AEMT and Paramedic Programs: Proposed dates and locations of the didactic and psychomotor certification examinations within ten (10) days of the course beginning date; and ()

e. Course completion record (roster) within ten (10) days after the student's course completion date. ()

02. Records to be Maintained. Each EMS Education Program must maintain documentation of the following: ()

a. Student competence in all areas listed in the Idaho EMS Education Standards for the level being taught; and ()

b. Student attendance in all didactic instruction, skills laboratories, hospital/clinical experience, and field experience. ()

03. Records Retention. All documentation related to a course or program must be retained for a minimum of five (5) years in a retrievable format. ()

109. -- 199. (RESERVED)

CRITERIA FOR EMS EDUCATION
(Sections 200 - 299)

200. INITIAL EMS EDUCATION REQUIREMENTS.

01. Content. ()

a. Idaho-Specific Content. All initial EMS courses must include the following Idaho-specific content, developed professionally and approved by the Department, if available: ()

- i. Physician Order for Scope of Treatment (POST); ()
- ii. Safe Haven; ()
- iii. Landing Zone Officer; and ()
- iv. Extrication Awareness. ()
- b.** National Content. All initial EMS courses must include the following national content: ()
 - i. Incident Command System ICS-100 and ICS-700; and ()
 - ii. HazMat Awareness. ()

02. Consistency with Scope of Practice. All curricula must be consistent with the Idaho scope of practice for licensed personnel as set forth in the EMS Physician Commission Standards Manual incorporated under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," which aligns with the clinical level of the course. ()

03. Consistency with State and National Standards. All curricula must be consistent with Idaho EMS Education Standards incorporated under Section 004 of these rules, and the National EMS Scope of Practice Model. ()

201. -- 209. (RESERVED)

210. OPTIONAL MODULE EMS EDUCATION.

01. Consistency with Scope of Practice. All optional module curricula must be consistent with the Idaho scope of practice for licensed personnel as set forth in the EMS Physician Commission Standards Manual, incorporated under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," which aligns with the clinical level of the course. ()

02. Consistency with State and National Standards. All optional module curricula must be consistent with Idaho EMS Education Standards incorporated under Section 004 of these rules, and the National EMS Scope of Practice Model. ()

211. -- 299. (RESERVED)

**EMS EDUCATION PROGRAM PERSONNEL REQUIREMENTS,
QUALIFICATIONS, AND RESPONSIBILITIES
(Sections 300-399)**

300. REQUIRED PERSONNEL FOR EMS EDUCATION PROGRAMS.

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

02. Teaching Faculty. Each program must identify a sufficient number of teaching faculty who meet the qualifications described below in Subsections 301.02 and 301.03 of these rules. ()

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

301. EMS EDUCATION PROGRAM PERSONNEL QUALIFICATIONS.

- 01. Program Director.** Program Directors must meet the following qualifications: ()
- a.** Have completed an Education Program Orientation Course within the previous twenty-four (24) months. ()
- b.** Have knowledge of current Idaho EMS Education Standards and the requirements for state certification and licensure. ()
- 02. Instructor.** Instructors must possess a current instructor certification issued by the Department. ()
- 03. Adjunct Faculty or Guest Lecturers.** Adjunct faculty and guest lecturers must be authorized by the course physician based on credentials, education, or expertise that corresponds to the knowledge and skill objectives they are teaching. ()
- 04. Course Physician.** Course physicians must meet the following qualifications: ()
- a.** Be a Doctor of Osteopathy (DO) or Medical Doctor (MD) currently licensed to practice medicine with experience and current knowledge of emergency care of acutely ill and injured patients; and ()
- b.** Have knowledge or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care. ()
- 302. EMS EDUCATION PROGRAM PERSONNEL RESPONSIBILITIES.**
An individual can have multiple personnel responsibilities, but must meet the applicable personnel requirements under Section 301 of these rules and fulfill all the responsibilities of each position they fill. ()
- 01. Program Director.** The program director's responsibilities include: ()
- a.** Administrative oversight of the program; ()
- b.** Ensuring that the program remains in compliance with these rules; and ()
- c.** Serving as the program's point of contact for the Department, or for a national EMS certification body, or both. ()
- 02. Instructor.** The instructor's responsibilities include: ()
- a.** Delivery of didactic and psychomotor education that satisfies the curriculum objectives; ()
- b.** Documentation of student performance and competency in accordance with the standards defined by the program; ()
- c.** Following program policies, requirements, and these rules; ()
- d.** Modeling positive behaviors and serving as a role model for students. ()
- 03. Course Physician.** The course physician's responsibilities are to provide: ()
- a.** Medical oversight for all medical aspects of instruction; and ()
- b.** Cooperative involvement with the program director. ()
- 303. -- 399. (RESERVED)**

EMS INSTRUCTOR CERTIFICATION

(Sections 400-499)

400. EMS INSTRUCTOR CERTIFICATION REQUIREMENTS.

01. Instructor Certification is Required. In order to serve as an EMS instructor, an individual must possess a current EMS instructor certificate issued by the Department. ()

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

a. Have successfully passed an Idaho criminal history and background check; ()

b. Have completed a Department-sponsored EMS Education Program Orientation Course within the preceding twenty-four (24) months; ()

c. Have completed a course that meets the requirements of an Adult Methodology Course as defined in Section 404 of these rules; ()

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

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

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

401. EMS INSTRUCTOR CERTIFICATE RENEWAL.

An individual applying for and meeting the EMS instructor certificate requirements defined in this rule will be issued a renewed EMS instructor certificate. To renew your instructor certificate you must: ()

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

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

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

04. Education Program Orientation Course. Complete a Department-sponsored program orientation course within their certification cycle. The program orientation course can be counted as instructor continuing education. ()

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

402. LAPSED EMS INSTRUCTOR CERTIFICATE.

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

02. Failure to Submit. An EMS instructor certificate will expire if an instructor fails to submit a

complete and timely renewal application. ()

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

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

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

06. Reinstatement of a Lapsed Certificate. Personnel with a lapsed EMS instructor certificate must complete the requirements listed in Subsection 400.02 of these rules to reinstate their instructor certificate. ()

403. CERTIFICATION OF CURRENTLY APPROVED EMS INSTRUCTORS.

01. Expiration of Approved Instructor Status. EMS instructor certificates issued prior to July 1, 2016, will expire on June 30, 2019. ()

02. Certification Process. An EMS instructor approved prior to July 1, 2016, must submit an application for renewal to the Department prior to June 30, 2019, in order to maintain an EMS instructor certificate. ()

03. Certificate Requirements. Currently approved EMS instructors who wish to maintain EMS instructor certification must meet the following requirements: ()

- a.** Have successfully passed an Idaho criminal history and background check; ()
- b.** Have completed a Department-sponsored Education Program Orientation Course orientation course within the preceding twenty-four (24) months; ()
- c.** Hold a current EMS license or EMS certificate at or above the instructor level requested; and ()
- d.** Have held an EMS license or EMS certificate at or above the level of instruction requested for a minimum of three (3) years. ()

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

404. ADULT METHODOLOGY REQUIREMENTS FOR EMS INSTRUCTORS.

Adult methodology requirements consist of completion of one (1) or more courses, developed professionally and approved by the Department, based on content that includes the following instructional topics: ()

- 01. The Adult Learner.** ()
- 02. Goals and Objectives.** ()
- 03. Learning Styles.** ()
- 04. Lesson Plans.** ()
- 05. Teaching Resources.** ()

- | | | |
|--------------|---|-----|
| 06. | Teaching Aids. | () |
| 07. | Teaching Methods. | () |
| 08. | Measurement and Evaluation Techniques. | () |
| 09. | Remediation, Communication, and Feedback. | () |
| 405. -- 499. | (RESERVED) | |

EMS EXAMINATIONS
(Sections 500 through 599)

500. STANDARDIZED EMS CERTIFICATION EXAMINATIONS.

A graduate of an EMS course must successfully complete psychomotor and cognitive certification examinations in order to qualify for EMS personnel licensure under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ()

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

a. Successful completion of the end-of-course examination described in Subsection 107.02.c. of these rules. ()

b. Successful completion of a level-appropriate psychomotor examination administered by the Department. ()

02. AEMT and Paramedic Psychomotor Examination. The psychomotor certification examination requirement for AEMT and Paramedic course graduates can only be met by successfully completing a formal Department-sponsored certification psychomotor examination. ()

03. Cognitive Examination. The cognitive certification examination requirement for all levels of course graduates can only be met by successfully completing the Idaho-approved certification cognitive examination. ()

501. OPTIONAL MODULE EMS EXAMINATIONS.

Psychomotor and cognitive examinations must be completed at the EMR and EMT levels once didactic education and training are successfully completed, as described in the EMS Physician Commission Standards Manual incorporated under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ()

502. EMS EXAM APPLICATIONS.

An organization other than the educational program that wishes to host a Department-administered examination must notify the Department at least sixty (60) days in advance of the proposed exam date. Educational programs must notify the Department in accordance with Section 108 of these rules. ()

503. -- 998. (RESERVED)

999. OTHER VIOLATIONS THAT MAY RESULT IN FORMAL ADMINISTRATIVE ACTION.

01. Unprofessional Conduct. Any act that violates the standards of professional conduct in Section 077 of these rules. ()

02. Failure to Maintain Standards of Knowledge, Proficiency, or Both. Failure to maintain standards of knowledge, or proficiency, or both, as required under these rules as well as: ()

a. IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensure Requirements"; and

()

b. IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission.” ()

03. Mental Incompetency. A lawful finding of mental incompetency by a court of competent jurisdiction. ()

04. Impairment of Function. Performance of duties under an EMS instructor certificate while under the influence of alcohol, an illegal substance, or a legal drug or medication causing impairment of function. ()

05. Denial of Criminal History Clearance. Any conduct, action, or conviction that does or would result in denial of a criminal history clearance under IDAPA 16.05.06, “Criminal History and Background Checks.” ()

06. Discipline, Restriction, Suspension, or Revocation. Discipline, restriction, suspension, or revocation by any other jurisdiction. ()

07. Danger or Threat to Persons or Property. Any conduct, condition, or circumstance determined by the EMS Bureau that constitutes a danger or threat to the health, safety, or well-being of persons or property. ()

08. Falsification of Applications or Reports. The submission of fraudulent or false information in any report, application, or documentation to the EMS Bureau. ()

09. Attempting to Obtain a Certificate by Means of Fraud. Misrepresentation in an application, or documentation, for certification by means of concealment of a material fact. ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.07 - EMERGENCY MEDICAL SERVICES (EMS) -- PERSONNEL LICENSING REQUIREMENTS

DOCKET NO. 16-0107-1502

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

The EMS Personnel Licensing rules are being aligned with a new chapter of rules that provide the education, instructor, and examination standards an individual must meet to be a licensed EMS provider in Idaho. Changes are being made to the pending rule to correct the licensing renewal continuing education table that did not list the Paramedic requirements in the original proposed rule docket. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 71 through 88](#).

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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Bruce Cheeseman at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

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

Tuesday, August 11, 2015 - 10:00 a.m. MDT

**2224 East Old Penitentiary Road
Boise, ID 83712**

**PARTICIPATION BY WEBINAR
(for those who are unable to attend the hearing)**

**To join the webinar, go to:
<https://global.gotomeeting.com/join/553709749>**

Use your microphone and speakers (VoIP) -- a headset is recommended. Or, call in using your telephone.

Dial: 1 (646) 749-3122
Access Code: 553-709-749

**Audio PIN: Shown after joining the meeting using URL above
Meeting ID: 553-709-749**

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

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

The EMS Personnel Licensing rules are being amended to align with a new chapter of rules being written that provide the education, instructor, and examination standards an individual must meet to be a licensed EMS provider in Idaho. These rules also include temporary rule changes for continuing education venues and licensing renewal cycle requirements that were extended by the 2015 Legislature. For consistency, this chapter includes references and sections from the repeal of IDAPA 16.02.03, "Emergency Medical Services," and the new chapter in IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructors, and Examination Requirements."

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

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not held. However, the Department held a number of meetings around the state with EMS personnel and agencies. The changes in this rule concerning continuing education were based on concerns voiced during those meetings and required the Department to amend these rules prior to the end of the current licensure period.

INCORPORATION BY REFERENCE: There are no documents incorporated in this rulemaking.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

Italicized red text that is double underscored is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0107-1502

004. INCORPORATION BY REFERENCE.

~~The Department has incorporated by reference the "Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual," edition 2012-1. Copies of this Standards Manual may be obtained from the EMS Bureau described in Section 005 of these rules, or online at: <http://www.emspe.dhw.idaho.gov>.~~ No documents have been incorporated by reference into these rules. (3-29-12)()

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Confidentiality of Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (3-29-12)

02. Public Records Act. The Department will comply with ~~Sections 9-337 through 9-350~~ Title 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (3-29-12)()

(BREAK IN CONTINUITY OF SECTIONS)

075. INVESTIGATION OF COMPLAINTS FOR PERSONNEL LICENSING VIOLATIONS.

Investigation of complaints and disciplinary actions for personnel licensing are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." ()

076. ADMINISTRATIVE ACTION IMPOSED FOR LICENSE OR CERTIFICATION.

Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions imposed by the EMS Bureau for any action, conduct, or failure to act which is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." ()

0757. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS PERSONNEL.

01. Method of Treatment. EMS personnel must practice medically acceptable methods of treatment and must not endeavor to extend their practice beyond their competence and the authority vested in them by the medical director. EMS personnel must not perform any medical procedure or provide medication that deviated from

or exceeds the scope of practice for the corresponding level of licensure established under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ~~(3-29-12)~~()

02. Knowledge and Proficiency. EMS personnel must maintain standards of knowledge and proficiency as required by this chapter of rules and IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." ()

~~**02. Commitment to Self-Improvement.** EMS personnel must continually strive to increase and improve their knowledge and skills and render to each patient the full measure of their abilities.~~ ~~(3-29-12)~~

03. Respect for the Patient. EMS personnel must provide all services with respect for the dignity of the patient, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. (3-29-12)

04. Confidentiality. EMS personnel must hold in strict confidence all privileged information concerning the patient except as disclosure or use of this information is permitted or required by law or Department rule. (3-29-12)

05. Conflict of Interest. EMS personnel must not accept gratuities for preferential consideration of the patient and must guard against conflicts of interest. (3-29-12)

06. Professionalism. EMS personnel must uphold the dignity and honor of the profession and abide by its ethical principles and ~~should~~ must be familiar with existing laws governing the practice of emergency medical services and comply with those laws. EMS personnel must never perform duties of the profession while under the influence of alcohol, illegal substances, or legal drugs or medication causing impairment of function. ~~(3-29-12)~~()

07. Cooperation and Participation. EMS personnel must cooperate with other health care professionals and participate in activities to promote community and national efforts to meet the health needs of the public. (3-29-12)

08. Ethical Responsibility. EMS personnel must refuse to participate in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner. Misrepresentation in an application or documentation for licensure by means of concealment of a material fact is a violation of ethical responsibility. ~~(3-29-12)~~()

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

~~0768.~~ -- ~~0989.~~ (RESERVED)

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

091. -- 099. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

106. TIME FRAME FOR PERSONNEL LICENSURE AFTER SUCCESSFUL COMPLETION OF EDUCATION COURSE.

An individual who has successfully completed an EMS education course is eligible to attempt the certification ~~standardized~~ examination for the appropriate level of licensure. ~~(3-29-12)~~()

01. Complete Standardized ~~Certification~~ Examination. A candidate must successfully complete all components of the standardized certification examination in a twelve (12) month period within twenty-four (24) months of completing an EMS training course in order to be eligible for an Idaho EMS personnel license.

(3-29-12)()

02. **Certification Standardized Examination Not Completed.** If all components of the standardized ~~certification~~ examination are not successfully completed in a twelve (12) month period within twenty-four (24) months of course completion, the candidate must repeat the initial training course and all components of the ~~certification~~ standardized examination in order to be eligible for an Idaho EMS personnel license. (3-29-12)()

107. -- 109. (RESERVED)

110. INITIAL PERSONNEL LICENSURE.

Upon successful completion of an approved education course recognized by the EMS Bureau under IDAPA 16.021.035, "Emergency Medical Services -- Education, Instructor, and Examination Requirements," an individual may apply to the EMS Bureau for licensure. The candidate must meet the following: (3-29-12)()

01. **Candidate Age Requirements.** An individual applying for licensure must meet the following age requirements: (3-29-12)

a. An EMR and EMT candidate must be either sixteen (16) or seventeen (17) years old with parental or legal guardian consent, or eighteen (18) years old. (3-29-12)

b. An AEMT and Paramedic candidate must be eighteen (18) year old. (3-29-12)

02. **Declaration of Previous Applications and Licensures.** A candidate must declare each state or jurisdiction in which he has applied for, been denied, or held an EMS license or certification. (3-29-12)

03. **Authorization for Release of Information.** A candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. (3-29-12)

04. **Provide Current Affiliation with EMS Agency.** A candidate must declare all organizations in which they are allowed to practice as licensed personnel. A candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. (3-29-12)

05. **Valid Identification.** A candidate must have a valid state driver's license, an Idaho identification card issued by a county driver's license examining station, or an identification card issued by the Armed Forces of the United States. (3-29-12)

06. **Criminal History and Background Check.** A candidate must successfully complete a criminal history and background check according to the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," will result in denial or revocation of licensure. (3-29-12)

07. **Pass Standardized Examination.** A candidate must successfully complete the standardized examination for the level of licensure on the application required under IDAPA 16.021.035, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements." (3-29-12)()

a. A candidate for EMR licensure must have successfully completed the standardized ~~certification~~ examination at the EMR level or higher within the preceding thirty-six (36) months. (3-29-12)()

b. A candidate for EMT licensure must have successfully completed the standardized ~~certification~~ examination at the EMT level or higher within the preceding thirty-six (36) months. (3-29-12)()

c. A candidate for AEMT licensure must have successfully completed the standardized ~~certification~~ examination at the AEMT level or higher within the preceding twenty-four (24) months. (3-29-12)()

d. A candidate for Paramedic licensure must have successfully completed the standardized ~~certification~~ examination at the Paramedic level within the preceding twenty-four (24) months. (3-29-12)()

08. Standardized Exam Attempts For Initial Licensure. A candidate for initial licensure is allowed to attempt to successfully pass the standardized exam as follows: (3-29-12)

a. An EMR candidate is allowed three (3) attempts to pass the exam, after which the initial EMR course must be successfully completed again before another three (3) attempts are allowed. (3-29-12)

b. An EMT candidate is allowed three (3) attempts to pass the exam, after which twenty-four (24) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-29-12)

c. An AEMT candidate is allowed three (3) attempts to pass the exam, after which thirty-six (36) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-29-12)

d. A Paramedic candidate is allowed three (3) attempts to pass the exam, after which forty-eight (48) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-29-12)

09. Submit Required Licensure Fee. A candidate must submit the applicable initial licensure fee provided in Section 111 of these rules. A candidate for EMR or EMT level of licensure has no fee requirement. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

116. PERSONNEL LICENSE TRANSITION.

Between the years of 2011 and 2016⁷, the scope of practice and the accompanying license levels for EMS personnel will change. The scope of practice for licensed EMS personnel is provided in ~~the~~ IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual incorporated by reference under Section 004 of these rules." Personnel licensed at the AEMT level can opt to either transition to the AEMT-2011 level, or they may remain at the AEMT-1985 level. In order to renew a license, personnel licensed at the EMR, EMT, or Paramedic level must transition and meet the following requirements. (3-29-12)()

01. General Transition Requirements for Licensed Personnel. Licensed personnel transitioning to a new licensure level must: (3-29-12)

a. Successfully complete an Idaho-approved transition course appropriate for the level of licensure; (3-29-12)

b. Provide documentation of verification by the course physician of competency in the knowledge and skills identified in the appropriate transition course curriculum; and (3-29-12)

c. Include proof of completion of transition requirements with the license renewal application. All other license renewal requirements listed in Section 120 of these rules must be completed. The transition course may be counted towards the renewal continuing education requirements. (3-29-12)

~~**02. Transition Options Specific for Personnel Licensed at the AEMT Level.** Personnel licensed at the AEMT level have options specific to transitioning as follows: (3-29-12)~~

~~**a.** In addition to the general transition requirements under Subsection 116.01 of this rule, personnel licensed at the AEMT level may choose to transition to the AEMT 2011. To transition to the AEMT 2011 level, the applicant must successfully pass the Idaho-approved written and practical examinations for that level of licensure by the deadlines provided in Subsection 116.03.b of this rule. (3-29-12)~~

~~**b.** Personnel licensed at the AEMT level who choose not to complete the transition requirements according to Subsection 116.03.b. of this rule, will be allowed to renew their personnel license at the AEMT-1985 level, if all other license renewal requirements listed in Section 120 of these rules are met. (3-29-12)~~

032. **Application Deadlines for Transition of Licensed Personnel.** Licensed personnel who choose to transition must submit an “EMS Personnel License Transition Application” according to the following deadline dates: (3-29-12)

a. For personnel licensed at the EMR and EMT levels, an application for transition must be submitted after January 1, 2012, and before ~~September 30, 2014~~ March 31, 2016, according to the effective date of the initial license or renewal date provided in the table below:

Table 116.032.a. PERSONNEL LICENSED AT EMR AND EMT LEVELS - TRANSITION DEADLINE DATES	
Effective Date of Initial License April 1, 2011 – September 30, 2011 October 1, 2011 – December 31, 2011	Date Transition Requirements MUST be Completed September 30, 2014 March 31, 2015
Effective Date of Renewed License April 1, 2011 October 1, 2011 April 1, 2012 October 1, 2012 April 1, 2013 October 1, 2013 <u>April 1, 2014</u>	Date Transition Requirements MUST be Completed March 31, 2014 September 30, 2014 March 31, 2015 September 30, 2015 March 31, 2016 September 30, 2016 <u>March 31, 2017</u>

(3-29-12)()

~~**b.** For personnel licensed at the AEMT and Paramedic levels, an application for transition must be submitted after January 1, 2013, and before September 30, 2015, according to the effective date of the initial license or renewal date provided in the table below:~~

Table 116.03.b.- PERSONNEL LICENSED AT AEMT AND PARAMEDIC LEVELS - TRANSITION DEADLINE DATES	
Effective Date of Initial License April 1, 2012 – September 30, 2012 October 1, 2012 – December 31, 2012	Date Transition Requirements MUST be Completed September 30, 2014 March 31, 2015
Effective Date of Renewed License April 1, 2012 October 1, 2012 April 1, 2013 October 1, 2013	Date Transition Requirements MUST be Completed March 31, 2014 September 30, 2014 March 31, 2015 September 30, 2015

(3-29-12)()

043. **Early Transition of Licensed Personnel.** Licensed personnel who meet all transition requirements and choose to transition prior to their license renewal date will be issued a license as follows: (3-29-12)

a. Continuing education completed between the effective date of the pre-transition license and the

expiration date of the transitioned license may be used to meet requirements listed in Section 120 of these rules for renewal of the transition license; (3-29-12)

- b. The new license will have the same expiration date as the current license; and (3-29-12)
- c. The new license will have a new effective date, based on the date the transition was approved by the EMS Bureau. (3-29-12)

117. -- 119. (RESERVED)

120. PERSONNEL LICENSE RENEWAL.

Licensed personnel must provide documentation that they meet the following requirements: (3-29-12)

01. Documentation of Affiliation with EMS Agency. A candidate applying for renewal of licensure must be affiliated with a licensed EMS agency which functions at, or above, the level of licensure being renewed. Documentation that the license holder is currently credentialed or undergoing credentialing by an affiliating EMS agency medical director must be submitted as assurance of affiliation for license renewal. (3-29-12)

02. Documentation of Continuing Education for Level of Licensure Renewal. A candidate for renewal of licensure must provide documentation of continuing education consistent with the license holder's level of licensure. All continuing education and skill proficiency requirements must be completed under the provisions in Sections 300 through 325 of these rules. The time frame for continuing education courses must meet the following requirements: ~~(3-29-12)~~()

a. All continuing education and skill proficiency requirements for renewal of an initial Idaho personnel license must be completed as follows: (3-29-12)

- i. For EMR or EMT, within the thirty-six (36) months preceding ~~renewal expiration.~~ ~~(3-29-12)~~()
- ii. For AEMT and Paramedic, within the twenty-four (24) months preceding ~~renewal expiration.~~ ~~(3-29-12)~~()

b. All continuing education and skill proficiency requirements for successive licenses must be completed between the effective and expiration dates of the license being renewed, or according to Section 116 ~~or 125~~ of these rules. ~~(3-29-12)~~()

c. All continuing education and skill proficiency requirements for renewal of licenses obtained through conversion of a Certificate of Eligibility must be completed as follows: (3-29-12)

- i. For EMR or EMT, within the thirty-six (36) months preceding ~~renewal expiration.~~ ~~(3-29-12)~~()
- ii. For AEMT and Paramedic, within the twenty-four (24) months preceding ~~renewal expiration.~~ ~~(3-29-12)~~()

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

03. Declarations of Convictions or Adjudications. A candidate for renewal of licensure must provide a declaration of any misdemeanor or felony adjudications. (3-29-12)

04. Time Frame for Application of Licensure Renewals. Documentation of license renewal requirements is due to the EMS Bureau prior to the license expiration date. Failure to submit a complete renewal application by the license expiration date renders the license invalid and the individual must not practice or represent himself as a license holder. (3-29-12)

05. Submit Required Licensure Renewal Fees. A candidate must submit the applicable license renewal fee provided in Section 111 of these rules. A candidate for EMR or EMT level of licensure has no fee requirement. (3-29-12)

121. -- 124. (RESERVED)

125. SUBMISSION OF EMS PERSONNEL LICENSURE APPLICATION AND DOCUMENTATION. Each EMS personnel license holder or candidate is responsible for meeting license renewal requirements and submitting completed license renewal documentation to the EMS Bureau by the current license expiration date. (3-29-12)

01. Earliest Submission Date for License Renewal. ()

a. Licensed EMS personnel may submit renewal application and documentation to the EMS Bureau up to six (6) months prior to the current license expiration date. (3-29-12)()

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

02. EMS Personnel License Expiration Date Falls on a Non-Work Day. When a license expiration date falls on a weekend, holiday, or other day the EMS Bureau is closed, the EMS Bureau will accept applications until the close of the next regular business day following the non-work day. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

131. REINSTATEMENT OF A LAPSED EMS PERSONNEL LICENSE.

An individual desiring to reinstate a lapsed personnel license must provide documentation that he meets the following requirements: (3-29-12)

01. Declaration of Previous Applications and Licensures. A reinstatement candidate must declare each state or jurisdiction in which he has applied for, been denied, or held an EMS license or certification. (3-29-12)

02. Authorization for Release of Information. A reinstatement candidate must provide authorization for the EMS authority in other states or jurisdictions to release the candidate's registration, licensure, and certification information to the Idaho EMS Bureau. (3-29-12)

03. Provide Current Affiliation with EMS Agency. A reinstatement candidate must declare all organizations in which they are allowed to practice as licensed personnel. The candidate must have a current affiliation with a licensed EMS agency that functions at, or above, the level of licensure being sought by the candidate. (3-29-12)

04. Documentation of Continuing Education for Lapsed License Reinstatement. A candidate for reinstatement of a lapsed license must provide documentation of continuing education consistent with the license holder's lapsed license. Continuing education requirements are provided in Sections 300 through 332 of these rules. The time frame for meeting the continuing education requirements for reinstatement are as follows: (3-29-12)()

a. The candidate must meet continuing education requirements under Sections 320 through 332 of these rules for the last valid licensure cycle; and (3-29-12)()

b. Additional continuing education hours in any combination of categories and venues, proportionate to the amount of time since the expiration date of the lapsed license, as follows: (3-29-12)

i. EMR -- Three-quarters (3/4) of one (1) hour of continuing education per month of lapsed time. (3-29-12)

- ii. EMT -- One and one-half (1 ½) hours of continuing education per month of lapsed time. (3-29-12)
- iii. AEMT -- Two and one-quarter (2 ¼) hours of continuing education per month of lapsed time. (3-29-12)
- iv. Paramedic -- Three (3) hours of continuing education per month of lapsed time. (3-29-12)

05. Valid Identification for Reinstatement of Lapsed License. A reinstatement candidate must have a valid state driver's license, an Idaho identification card which is issued by a county driver's license examining station, or identification card issued by the Armed Forces of the United States. (3-29-12)

06. Criminal History and Background Check for Reinstatement of Lapsed License. A reinstatement candidate must successfully complete a criminal background check under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Denial without the grant of an exemption under IDAPA 16.05.06 will result in denial of reinstatement of licensure. (3-29-12)

07. Pass Standardized Examination for Reinstatement. A reinstatement candidate must successfully complete the standardized examination for the lapsed level of licensure required under IDAPA 16.021.035, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements." A candidate for reinstatement must successfully complete the standardized ~~certification~~ examination within the time period during which the license was lapsed. (3-29-12) ()

08. Standardized Exam Attempts For Reinstatement. A candidate for licensure reinstatement is allowed to attempt to successfully pass the standardized exam as follows: (3-29-12)

- a. An EMR candidate is allowed three (3) attempts to pass the exam, after which the initial EMR course must be successfully completed again before another three (3) attempts are allowed. (3-29-12)
- b. An EMT candidate is allowed three (3) attempts to pass the exam, after which twenty-four (24) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-29-12)
- c. An AEMT candidate is allowed three (3) attempts to pass the exam, after which thirty-six (36) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-29-12)
- d. A Paramedic candidate is allowed three (3) attempts to pass the exam, after which forty-eight (48) hours of remedial education must be successfully completed before another three (3) attempts are allowed. (3-29-12)

09. Submit Required Licensure Fee for Reinstatement. A candidate must submit the applicable reinstatement license fee provided in Section 111 of these rules. A candidate for reinstatement of an EMR or EMT level of licensure has no fee requirement. (3-29-12)

10. Expiration Date of a Reinstated License. The expiration date for a lapsed license that is reinstated is determined as provided in Section 115 of these rules. (3-29-12)

11. Reinstatement During Transition. A candidate may reinstate his lapsed license only if he has completed transition requirements for his level of licensure. Education obtained in a transition course may be used to meet the CEU requirements for reinstatement according to Section 300 of these rules. (3-29-12)

132. -- 139. (RESERVED)

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

01. EMS Personnel Licensed or Certified in Other States. An individual, possessing an EMS personnel license or certification from a state other than Idaho, must have prior recognition or reciprocity granted by the EMS Bureau prior to providing emergency medical care in Idaho. The following applies: (3-29-12)

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

(3-29-12)

b. An individual who is currently licensed or certified by another ~~State~~ to provide emergency medical care can apply to the EMS Bureau for limited recognition to practice in Idaho. ~~Limited recognition does not grant an individual the ability to practice outside of those specified and approved by the EMS Bureau.~~ as provided in Subsection 140.02 of this rule.

~~(3-29-12)~~ ()

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

()

03. Personnel with NREMT Registration or Current EMS Certification. An individual, possessing a current NREMT registration or a current EMS certification or license from another state at or above the level of licensure they are seeking in Idaho, is eligible for an Idaho EMS personnel licensure if they satisfy the requirements in Section 110 of these rules ~~prior to providing emergency medical care in Idaho.~~

~~(3-29-12)~~ ()

04. Personnel Licensure Candidate Trained in Other States. A candidate trained outside of Idaho must apply for and obtain an Idaho EMS license as required in Section 110 of these rules prior to providing emergency medical care in Idaho. A declaration that the candidate is fully eligible for EMS licensure in the state in which he was trained, must be obtained from the EMS licensing authority in that state and submitted to the EMS Bureau.

(3-29-12)

~~03. Individual With a NREMT Registration. An individual possessing only a registration with the National Registry of Emergency Medical Technicians (NREMT) must obtain an Idaho EMS personnel license as required in Section 110 of these rules prior to providing emergency medical care in Idaho.~~

~~(3-29-12)~~

(BREAK IN CONTINUITY OF SECTIONS)

300. CONTINUING EDUCATION AND SKILLS PROFICIENCY.

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

(3-29-12)

02. Documentation of Continuing Education. Licensed personnel must maintain documentation of all continuing education as follows:

(3-29-12)

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

(3-29-12)

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

(3-29-12)

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

(3-29-12)

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

(3-29-12)

- b. Education must be completed during a single license duration. (3-29-12)

~~04~~301. CONTINUING EDUCATION RECORDS ARE SUBJECT TO AUDIT.

The EMS Bureau reserves the right to audit continuing education records to verify that renewal requirements have been met. (3-29-12)

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

a. Name of attendee: ()

b. Date education was completed; and ()

c. Education sponsor or instructor. ()

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

a. Signed course roster: ()

b. Certificate of completion: ()

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

d. Verification of attendance from EMS conference: ()

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

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

30~~1~~2. -- 304. (RESERVED)

305. CONTINUING EDUCATION CATEGORIES FOR PERSONNEL LICENSURE RENEWAL.

01. ~~Pediatric Assessment and Management~~ Airway. (3-29-12)()

02. ~~Anatomy and Physiology~~ Cardiovascular. (3-29-12)()

03. ~~Medical Terminology~~ Trauma. (3-29-12)()

04. ~~Pathophysiology~~ Medical. (3-29-12)()

05. ~~Life Span Development~~ Operations. (3-29-12)()

06. ~~Public Health~~ Pediatrics. (3-29-12)()

07. ~~Pharmacology.~~ (3-29-12)

08. ~~Airway Management, Ventilation, and Oxygenation.~~ (3-29-12)

09. ~~Patient Assessment.~~ (3-29-12)

10. ~~Medical Conditions.~~ (3-29-12)

11. ~~Shock and Resuscitation.~~ (3-29-12)

12. ~~Trauma.~~ (3-29-12)

~~13. Special Patient Populations. Such as bariatric, geriatric, obstetrics, pregnancy, etc. (3-29-12)~~

~~14. EMS Systems and Operations. (3-29-12)~~

306. -- 309. (RESERVED)

310. VENUES OF CONTINUING EDUCATION FOR PERSONNEL LICENSURE RENEWAL.

Continuing education for all personnel must include at least two (2) of the venues described in Subsections 310.01 through 310.12 of this rule for each licensure period. ()

01. Structured Classroom Sessions. (3-29-12)

02. Refresher Programs. Refresher programs that revisit the original curriculum and have an evaluation component (3-29-12)

03. Nationally Recognized Courses. (3-29-12)

04. Regional and National Conferences. (3-29-12)

05. Teaching Continuing Education Topics. The continuing education topics being taught must fall under the categories in Section 305 of these rules. (3-29-12)

06. Agency Medical Director-Approved Self-Study or Directed Study. This venue is not allowed to be used for a certificate of eligibility continuing education requirement ~~under Section 350 of these rules.~~ (3-29-12)()

07. Case Reviews and Grand Rounds. (3-29-12)

08. Distributed Education. This venue includes distance and blended education using computer, video, audio, Internet, and CD resources (3-29-12)

09. Journal Article Review with an Evaluation Instrument. (3-29-12)

10. Author or Co-Author an EMS-Related Article in a Nationally Recognized Publication. ~~The article must be published in an EMS-specific publication.~~ (3-29-12)()

11. Simulation Training. ()

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

311. -- 319. (RESERVED)

320. ~~EMR-LEVEL~~ LICENSE RENEWAL CONTINUING EDUCATION ~~AND SKILLS PROFICIENCY~~ REQUIREMENTS.

~~An EMR-level license renewal candidate must provide documentation of the following continuing education hours provided in the table below during each licensure period.~~ (3-29-12)()

~~**01. EMR Level Continuing Education Hours Needed for License Renewal.** A candidate must provide proof of successful completion of twenty-four (24) hours of continuing education. The types of continuing education courses and the number of hours required for EMR-level licensure are:~~ (3-29-12)

~~**a.** A minimum of two (2) hours in pediatrics;~~ (3-29-12)

~~**b.** A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows:~~ (3-29-12)

~~i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)~~

~~ii. For extrication awareness training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)~~

~~e. Two (2) hours in six (6) categories other than pediatrics and EMS Systems and Operations listed in Section 305 of these rules, for twelve (12) continuing education hours; and (3-29-12)~~

~~d. Seven (7) hours of continuing education can be from any single category or combination of categories listed in Section 305 of these rules. (3-29-12)~~

02. Skills Proficiency for EMR Level License Renewal. ~~A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the EMR licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows: (3-29-12)~~

~~a. Recognize and manage acute traumatic and medical life threats or conditions based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and (3-29-12)~~

~~b. Specific skills for an EMR that includes: (3-29-12)~~

~~i. Airway, ventilation, and oxygenation; (3-29-12)~~

~~ii. Cardiovascular and circulation; (3-29-12)~~

~~iii. Immobilization; (3-29-12)~~

~~iv. Medication administration; (3-29-12)~~

~~v. Normal childbirth; (3-29-12)~~

~~vi. Patient care reporting documentation; and (3-29-12)~~

~~vii. Safety and operations. (3-29-12)~~

TABLE 320 LICENSE RENEWAL CONTINUING EDUCATION (CE) REQUIREMENTS				
CE CATEGORIES	EMR 24 TOTAL CE Hours	EMT 48 TOTAL CE Hours	AEMT 54 TOTAL CE Hours	PARAMEDIC 72 TOTAL CE Hours
An individual must complete at least 1 hour of continuing education in each category.				
Airway, Respiration, and Ventilation	No more than 7 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 14 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 16 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.	No more than 22 CE hours in any single category may be counted toward the total number of CE Hours needed for renewal.
Cardiovascular				
Trauma				
Medical				
Operations: Landing Zone & Extrication Awareness				
Pediatrics	2 hours	4 hours	6 hours	8 hours

()

321. -- 324. (RESERVED)

325. **EMT-LEVEL LICENSE RENEWAL CONTINUING EDUCATION AND SKILLS PROFICIENCY REQUIREMENTS.**

An **EMT-level** license renewal candidate must provide documentation of the following during each licensure period demonstrate proficiency in the skills necessary to provide safe and effective patient care at the licensure level consistent with the scope of practice provided in IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (3-29-12)()

01. EMT-Level Continuing Education Hours Needed for License Renewal. A candidate must provide proof of successful completion of forty-eight (48) hours of continuing education. The types of continuing education courses and the number of hours needed for EMT-level licensure are: (3-29-12)

- a. A minimum of four (4) hours in pediatrics; (3-29-12)
- b. A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows: (3-29-12)
 - i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)
 - ii. For extrication awareness training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)
- c. Four (4) hours in eight (8) categories other than pediatrics and EMS Systems and Operations listed in Section 305 of these rules for thirty-two (32) hours; and (3-29-12)
- d. Nine (9) hours can be from any single category or combination of categories listed in Section 305

~~of these rules. (3-29-12)~~

~~**02. Venues Where Continuing Education May be Taken.** Continuing education for personnel licensed at the EMT level must include four (4) of the continuing education venues listed in Section 310 of these rules during each licensure period. (3-29-12)~~

~~**03. Skills Proficiency for EMT Level License Renewal.** A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the EMT licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows: (3-29-12)~~

~~**a.** Recognize and manage acute traumatic and medical life threats or conditions based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and (3-29-12)~~

~~**b.** Specific skills for an EMT that includes: (3-29-12)~~

~~i. Airway, ventilation, and oxygenation; (3-29-12)~~

~~ii. Cardiovascular and circulation; (3-29-12)~~

~~iii. Immobilization; (3-29-12)~~

~~iv. Medication administration; (3-29-12)~~

~~v. Normal and complicated childbirth; (3-29-12)~~

~~vi. Patient care reporting documentation; and (3-29-12)~~

~~vii. Safety and transport operations. (3-29-12)~~

~~**326.—329. (RESERVED)**~~

~~**330. AEMT LEVEL LICENSE RENEWAL CONTINUING EDUCATION AND SKILLS PROFICIENCY REQUIREMENTS.**~~

~~An AEMT license renewal candidate must provide documentation of the following during each licensure period: (3-29-12)~~

~~**01. AEMT Level Continuing Education Hours Needed for License Renewal.** A candidate must provide proof of successful completion of fifty four (54) hours of continuing education. The types of continuing education courses and the number of hours needed for AEMT level licensure are: (3-29-12)~~

~~**a.** A minimum of six (6) hours in pediatrics; (3-29-12)~~

~~**b.** A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows: (3-29-12)~~

~~i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)~~

~~ii. For extrication awareness training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)~~

~~**c.** Four (4) hours in nine (9) categories other than pediatrics and EMS Systems and Operations listed in Section 305 of these rules, for thirty six (36) hours; and (3-29-12)~~

~~**d.** Nine (9) hours of continuing education can be from any single category or combination of categories listed in Section 305 of these rules. (3-29-12)~~

~~02. Venues Where Continuing Education for AEMT License Renewal May be Taken. Continuing education for personnel licensed at the AEMT level must include four (4) of the continuing education venues listed in Section 310 of these rules during each licensure period. (3-29-12)~~

~~03. Skills Proficiency for AEMT Level License Renewal. A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the AEMT licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows: (3-29-12)~~

~~a. Recognize and manage acute traumatic and medical life threats or conditions based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and (3-29-12)~~

~~b. Specific skills for an AEMT that includes: (3-29-12)~~

~~i. Advanced airway, ventilation, and oxygenation; (3-29-12)~~

~~ii. Cardiovascular and circulation; (3-29-12)~~

~~iii. Immobilization; (3-29-12)~~

~~iv. Medication administration; (3-29-12)~~

~~v. Normal and complicated childbirth; (3-29-12)~~

~~vi. Patient care reporting documentation; (3-29-12)~~

~~vii. Safety and transport operations; and (3-29-12)~~

~~viii. Vascular access. (3-29-12)~~

~~331.—334. (RESERVED)~~

~~335. PARAMEDIC LEVEL LICENSE RENEWAL CONTINUING EDUCATION AND SKILLS PROFICIENCY REQUIREMENTS.~~

~~A paramedic license renewal candidate must provide documentation of the following during each licensure period. (3-29-12)~~

~~01. Paramedic Level Continuing Education Hours Needed for License Renewal. A candidate must provide proof of successful completion of seventy-two (72) hours of continuing education. The types of continuing education courses and the number of hours needed for paramedic level licensure are: (3-29-12)~~

~~a. A minimum of eight (8) hours in pediatrics; (3-29-12)~~

~~b. A minimum of three (3) hours in EMS Systems and Operations earned by completing state-approved Landing Zone Officer (LZO) and extrication awareness training. Continuing education hours are awarded as follows: (3-29-12)~~

~~i. For LZO training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)~~

~~ii. For extrication awareness training, two (2) hours in classroom presentation, or one (1) hour in distributed education; (3-29-12)~~

~~c. Four (4) hours in eleven (11) categories other than pediatrics and EMS Systems and Operations listed in Section 305 of these rules, for forty-four (44) hours; and (3-29-12)~~

~~d. Seventeen (17) hours can be from any single category or a combination of categories listed in~~

~~Section 305 of these rules.~~

~~(3-29-12)~~

~~02. **Venues Where Continuing Education for Paramedic Level License Renewal May be Taken.** Continuing education for personnel licensed at the paramedic level must include six (6) of the continuing education venues listed in Section 310 of these rules during each licensure period.~~

~~(3-29-12)~~

~~03. **Skills Proficiency for Paramedic Level License Renewal.** A candidate must demonstrate proficiency in the skills necessary to provide safe and effective patient care at the Paramedic licensure level under the authority of IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services Physician Commission," as follows:~~

~~(3-29-12)~~

~~a. Recognize and manage acute traumatic and medical life threats or conditions based on patient assessment findings for pediatric, adult, geriatric, and special needs patients; and~~

~~(3-29-12)~~

~~b. Specific skills for a Paramedic that includes:~~

~~(3-29-12)~~

~~i. Advanced airway, ventilation, and oxygenation, to include endotracheal intubation;~~

~~(3-29-12)~~

~~ii. Cardiovascular and circulation, to include cardiac rhythm interpretation;~~

~~(3-29-12)~~

~~iii. Immobilization;~~

~~(3-29-12)~~

~~iv. Medication administration, to include parenteral drug administration;~~

~~(3-29-12)~~

~~v. Normal and complicated childbirth;~~

~~(3-29-12)~~

~~vi. Patient care reporting documentation;~~

~~(3-29-12)~~

~~vii. Safety and transport operations;~~

~~(3-29-12)~~

~~viii. Vascular access; and~~

~~(3-29-12)~~

~~ix. Manual defibrillation.~~

~~(3-29-12)~~

~~336.—349. **(RESERVED)**~~

~~350. **CONTINUING EDUCATION AND SKILLS PROFICIENCY FOR RENEWAL OF CERTIFICATE OF ELIGIBILITY REQUIREMENTS.**~~

~~A certificate of eligibility renewal candidate must provide documentation demonstrating completion of the following during each period of eligibility.~~

~~(3-29-12)~~

~~01. **Examination.** A candidate must have successfully completed the standardized examination designated by the EMS Bureau for the certificate of eligibility.~~

~~(3-29-12)~~

~~02. **Continuing Education for Certificate of Eligibility Licensure Level.** A candidate must provide proof of successful completion of continuing education hours for the types of continuing education courses, the number of hours needed for a specific certificate of eligibility licensure level, and in the venues as required for the following:~~

~~(3-29-12)~~

~~a. EMR licensure level renewal required in Section 320 of these rules.~~

~~(3-29-12)~~

~~b. EMT licensure level renewal required in Section 325 of these rules.~~

~~(3-29-12)~~

~~c. AEMT licensure level renewal required in Section 330 of these rules.~~

~~(3-29-12)~~

~~d. Paramedic licensure level renewal required in Section 335 of these rules.~~

~~(3-29-12)~~

~~351. -- 399. (RESERVED)~~

~~400. INVESTIGATION OF COMPLAINTS FOR PERSONNEL LICENSING VIOLATIONS.~~

~~Investigation of complaints and disciplinary actions for personnel licensing are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) Complaints, Investigations, and Disciplinary Actions." (3-29-12)~~

~~401. ADMINISTRATIVE LICENSE OR CERTIFICATION ACTION.~~

~~Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions imposed by the EMS Bureau for any action, conduct, or failure to act which is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) Complaints, Investigations, and Disciplinary Actions." (3-29-12)~~

~~402~~³²⁶. -- 999. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.01.12 - EMERGENCY MEDICAL SERVICES (EMS) -- COMPLAINTS, INVESTIGATIONS, AND DISCIPLINARY ACTIONS

DOCKET NO. 16-0112-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1023, Idaho Code.

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

The EMS Complaints, Investigations, and Disciplinary Actions rules are being aligned with a new chapter of rules that provides the education, instructor, and examination standards an individual must meet to be a licensed EMS provider in Idaho. These rules also update enforcement actions that can be taken. No changes are being made in the pending rule and these rules are adopted as published in the original proposed rules. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 89 through 98](#).

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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Bruce Cheeseman at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1011 through 56-1023, Idaho Code.

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

Tuesday, August 11, 2015 - 10:00 a.m. MDT

2224 East Old Penitentiary Road
Boise, ID 83712

PARTICIPATION BY WEBINAR
(for those who are unable to attend the hearing)

To join the webinar, go to:
<https://global.gotomeeting.com/join/553709749>

Use your microphone and speakers (VoIP) -- a headset is recommended. Or, call in using your telephone.

Dial: 1 (646) 749-3122
Access Code: 553-709-749

Audio PIN: Shown after joining the meeting using URL above
Meeting ID: 553-709-749

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

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

These rules are being amended to align with a new chapter of rules that provides the education, instructor, and examination standards an individual must meet to be a licensed EMS provider in Idaho. These rules include additions and references to rules from IDAPA 16.02.03, "Emergency Medical Services," a chapter being repealed, and to the new chapter IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructors, and Examination Requirements."

Updates have been made to align these rules with the agency and personnel licensing requirements that provide clarity for enforcement actions that can be taken. Language for professional standards has been removed from this chapter and placed in the appropriate licensing chapter.

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

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

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was held under the Personnel Licensing and the Education chapters, but not specifically for this EMS chapter. The changes in this rule are being made for clarity and to align with the new education chapter and remove references to the repealed chapter.

INCORPORATION BY REFERENCE: There are no documents incorporated in this rulemaking.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0112-1501

001. TITLE AND SCOPE.

01. **Title.** The title of these rules is IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." (3-29-12)

02. **Scope.** These rules provide for the management of complaints, investigations, enforcement, and disciplinary actions by the EMS Bureau for personnel and agency licensure and certification, and educational programs and instructor approval. (3-29-12)()

(BREAK IN CONTINUITY OF SECTIONS)

110. REPORTING SUSPECTED VIOLATION.

01. **Suspected Violations.** Any person may report a suspected violation of any law or rule governing EMS, ~~including:~~ (7-1-14)()

~~a. Sections 56-1011 through 56-1023, Idaho Code;~~ (7-1-14)

~~b. IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission";~~ (7-1-14)

~~c. IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements";~~ (7-1-14)

~~d. IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements"; or~~ (7-1-14)

~~e. IDAPA 16.02.03, "Emergency Medical Services."~~ (7-1-14)

02. **Report Violation.** To report a suspected violation, contact the EMS Bureau described in Section 005 of these rules. (7-1-14)

(BREAK IN CONTINUITY OF SECTIONS)

200. EMS BUREAU INITIATES OFFICIAL INVESTIGATION.

An official investigation will be initiated when the any of the following occurs: (3-29-12)

01. **Complaint with Allegations.** A complaint with an allegation that, if substantiated, would be in

violation of any law or rule governing EMS, ~~including:~~ (7-1-14)()

- ~~a. Sections 56-1011 through 56-1023, Idaho Code;~~ (7-1-14)
- ~~b. IDAPA 16.01.03, "Emergency Medical Services (EMS) Agency Licensing Requirements";~~ (7-1-14)
- ~~c. IDAPA 16.01.07, "Emergency Medical Services (EMS) Personnel Licensing Requirements";~~ (7-1-14)
- ~~d. IDAPA 16.01.12, "Emergency Medical Services (EMS) Complaints, Investigations, and Disciplinary Actions";~~ (7-1-14)
- ~~e. IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission";~~ (7-1-14)
- ~~f. IDAPA 16.02.03, "Emergency Medical Services."~~ (7-1-14)

02. **Discovery of Potential Violation of Statute or Administrative Rule.** EMS Bureau staff or other authorities discover a potential violation of any law or rule governing EMS, ~~including:~~ (7-1-14)()

- ~~a. Sections 56-1011 through 56-1023, Idaho Code;~~ (7-1-14)
- ~~b. IDAPA 16.01.03, "Emergency Medical Services (EMS) Agency Licensing Requirements";~~ (7-1-14)
- ~~c. IDAPA 16.01.07, "Emergency Medical Services (EMS) Personnel Licensing Requirements";~~ (7-1-14)
- ~~d. IDAPA 16.01.12, "Emergency Medical Services (EMS) Complaints, Investigations, and Disciplinary Actions";~~ (7-1-14)
- ~~e. IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission";~~ (7-1-14)
- ~~f. IDAPA 16.02.03, "Emergency Medical Services."~~ (7-1-14)

201. -- 209. (RESERVED)

210. VIOLATIONS THAT MAY RESULT IN ADMINISTRATIVE ACTIONS.

The EMS Bureau may impose ~~an~~ administrative actions, ~~such as~~ including denial, revocation, suspension, or retention under conditions ~~that include, but are not limited to, those~~ specified in Sections 300 through 399 of these rules. Administrative actions may be imposed on any of the following: the holder of or an applicant or candidate for, an EMS license, or certificate, education program approval, or recognition ~~or on an applicant or candidate for an EMS license or certificate.~~ Administrative actions may be imposed on any of the previously mentioned for any action, conduct, or failure to act that is inconsistent with the professionalism, standards, or both, established by statute or rule. (3-29-12)()

- ~~01. Violation of Statute or Administrative Rules.~~ (3-29-12)
- ~~a. Sections 56-1011 through 56-1023, Idaho Code;~~ (3-29-12)
- ~~b. IDAPA 16.01.03, "Emergency Medical Services (EMS) Agency Licensing Requirements";~~ (7-1-14)
- ~~c. IDAPA 16.01.07, "Emergency Medical Services (EMS) Personnel Licensing Requirements";~~ (7-1-14)

- ~~d. IDAPA 16.01.12, "Emergency Medical Services (EMS) Complaints, Investigations, and Disciplinary Actions"; (7-1-14)~~
- ~~e. IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission"; (7-1-14)~~
- ~~and f. IDAPA 16.02.03, "Emergency Medical Services." (7-1-14)~~
- ~~02. Unprofessional Conduct. Any act that violates professional standards required under IDAPA 16.01.07, "EMS Personnel Licensure Requirements." (3-29-12)~~
- ~~03. Failure to Maintain Standards of Knowledge, Proficiency, or Both. Failure to maintain standards of knowledge, or proficiency, or both, required under: (7-1-14)~~
- ~~a. IDAPA 16.01.07, "Emergency Medical Services (EMS) Personnel Licensure Requirements"; and (7-1-14)~~
- ~~b. IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (7-1-14)~~
- ~~04. Mental Incompetency. A lawful finding of mental incompetency by a court of competent jurisdiction. (3-29-12)~~
- ~~05. Impairment of Function. Performance of duties pursuant to an EMS personnel license while under the influence of alcohol, illegal substance, or legal drug or medication causing impairment of function. (3-29-12)~~
- ~~06. Denial of Criminal History Clearance. Any conduct, action, or conviction that does or would result in denial of a criminal history clearance under IDAPA 16.05.06, "Criminal History and Background Checks." (3-29-12)~~
- ~~07. Discipline, Restriction, Suspension, or Revocation. Discipline, restriction, suspension, or revocation by any other jurisdiction. (3-29-12)~~
- ~~08. Danger or Threat to Persons or Property. Any conduct, condition, or circumstance determined by the EMS Bureau that constitutes a danger or threat to the health, safety, or well-being of persons or property. (3-29-12)~~
- ~~09. Performing Medical Procedure or Providing Medication that Exceeds the Scope of Practice of the Level of Licensure. Performing any medical procedure or providing medication that deviates from or exceeds the scope of practice for the corresponding level of licensure established under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission." (3-29-12)~~
- ~~10. Falsification of Applications or Reports. The submission of fraudulent or false information in any report, application, or documentation to the EMS Bureau. (3-29-12)~~
- ~~11. Attempting to Obtain a License by Means of Fraud. Misrepresentation in an application, or documentation, for licensure by means of concealment of a material fact. (3-29-12)~~

(BREAK IN CONTINUITY OF SECTIONS)

240. INVESTIGATION CONFIDENTIALITY.

- ~~01. Informal Resolution. Informal resolution of complaints or non-compliance by guidance or warning letter~~ negotiated resolution ~~is considered official correspondence and is~~ not public information.

~~(3-29-12)~~()

02. **Administrative License Action.** Preliminary investigations and documents supplied or obtained in connection with them are confidential until a formal notice of administrative license action is issued. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

300. ~~PERSONNEL~~ ACTIONS RESULTING FROM INVESTIGATIONS.

The following actions may be imposed upon the subject of an investigation by the EMS Bureau without peer review:

~~(3-29-12)~~()

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

~~(3-29-12)~~()

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

~~(3-29-12)~~()

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

~~(3-29-12)~~()

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

(3-29-12)

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

(3-29-12)

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

(3-29-12)

~~301.—309. (RESERVED)~~

~~310. AGENCY ACTIONS RESULTING FROM INVESTIGATIONS.~~

~~The following actions may be imposed upon an EMS agency that is the subject of an investigation by the EMS Bureau without peer review:~~

~~(3-29-12)~~

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

~~(3-29-12)~~

~~02. **Agency Warning Letter.** The EMS Bureau may issue a warning letter for a first offense where an organization is providing unlicensed emergency medical services in violation of Section 56-1021, Idaho Code.~~

~~(3-29-12)~~

~~03. **Negotiated Resolution for an Agency.** The EMS Bureau may negotiate a resolution with the subject of an investigation, where the allegations, if found to be true, did not cause, or is not likely to cause, injury or harm to the public or EMS system. The issue must be resolved within thirty (30) days of the negotiated resolution or a~~

~~settlement agreed to by both the subject of the investigation and the EMS Bureau. (3-29-12)~~

~~a. Negotiated resolution participants will include representatives from the EMS agency or the subject under investigation, EMS Bureau staff, and other parties deemed appropriate by the EMS Bureau. (3-29-12)~~

~~b. During the negotiated resolution process, the subject of the investigation may be offered specific remediation or disciplinary action by consent, which, if agreed to, will resolve the matter with no further right to appeal unless stipulated and agreed to at the time that the remediation or disciplinary action is agreed upon. (3-29-12)~~

~~c. When remediation or disciplinary action is not agreed to by consent of both the subject of the investigation and the EMS Bureau, the matter may then be referred to a peer review. (3-29-12)~~

310. -- 319. (RESERVED)

320. PEER REVIEW.

The EMS Bureau may elect to conduct a peer review for ~~an~~ alleged statute or rule violations when it determines that a peer review is an appropriate action, or a negotiated resolution or settlement agreement described in Section ~~300 and 310~~ of these rules, is not reached. The peer review is conducted as follows: (3-29-12)()

01. Review of Case by Peer Review Team. The peer review team reviews the case details, subject's background, affiliation, licensure history, associated evidence, and documents, and then considers aggravating and mitigating circumstance as follows: (3-29-12)

a. Aggravating circumstances can include: prior or multiple offenses, vulnerability of victim, obstruction of the investigation, and dishonesty. (3-29-12)

b. Mitigating circumstances can include: absence of prior offenses, absence of dishonest or selfish motive, timely effort to rectify situation, interim successful rehabilitation, misdirection per agency protocol, or medical direction. (3-29-12)

02. Subject Given Opportunity to Respond. The subject of the investigation will be given the opportunity to respond in writing, by teleconference, or at the option of the EMS Bureau, in person to the alleged violation. (3-29-12)

03. Evaluation of Evidence. The peer review team will evaluate the evidence and make a majority decision of the finding for each alleged statute, rule, or standards violation, including any additional detected violations. (3-29-12)

04. Recommend Action. The peer review team will recommend actions to the EMS Bureau. If subject is found to have violated statutes, rules, or standards, the recommendations may include the following: (3-29-12)

a. Administrative license action, time frames, conditions, and fines, if imposed, on an EMS agency: (3-29-12)()

b. Administrative license action, time frames, and conditions, if imposed, on EMS personnel: ~~or~~ (3-29-12)()

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

321. -- 329. (RESERVED)

330. ADMINISTRATIVE ACTIONS ~~IMPOSED FOR LICENSURE OR CERTIFICATION.~~

The EMS Bureau may impose the following administrative actions: (3-29-12)

01. Deny ~~or Refuse to Renew EMS Personnel License or Certification~~ Application. The EMS

Bureau may deny an application for an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or refuse to renew an EMS personnel license or instructor certification: (3-29-12)()

a. When the application ~~for licensure or certification~~ is not complete or the ~~individual applicant~~ does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission," or IDAPA 16.02.03, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements"; or (3-29-12)()

~~b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. (3-29-12)~~

~~eb.~~ For any reason that would justify an administrative action according to Section 210 of these rules. (3-29-12)

~~d. Decisions to deny or refuse to renew an EMS license will be reviewed by the Idaho EMS Physicians Commission at the Commission's next available meeting. (3-29-12)~~

02. ~~Deny or Refuse to Renew EMS Agency License.~~ The EMS Bureau may ~~deny an EMS agency license or refuse to renew an EMS personnel license, EMS personnel certificate of eligibility, EMS agency license, EMS education program approval, or EMS instructor certification~~: (3-29-12)()

a. When the renewal application ~~for licensure~~ is not complete or does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements," 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," or IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission"; or (7-1-14)()

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property; or (3-29-12)()

c. For any reason that would justify an administrative action according to Section 210 of these rules. (3-29-12)

03. ~~Retain with Probationary Conditions for Personnel License or Certification.~~ The EMS Bureau may allow the holder of an EMS personnel license, or EMS certificate holder of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification to retain a license, approval, or certificate as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. ~~Decisions to retain an EMS personnel license with probationary conditions will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. (3-29-12)()~~

~~04. Retain with Probationary Conditions for Agency License. The EMS Bureau may allow an EMS agency to retain a license as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. (3-29-12)~~

~~054.~~ ~~Suspend EMS Personnel License or Certificate.~~ The EMS Bureau may suspend an EMS personnel license, ~~or EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification~~ for: (3-29-12)()

a. A period of time up to twelve (12) months, with or without conditions; or (3-29-12)

b. Pending final outcome of an EMS investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. (3-29-12)()

~~e. Decisions to suspend an EMS personnel license will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting. (3-29-12)~~

065. Revoke ~~EMS Personnel License or Certificate~~. The EMS Bureau may revoke an EMS personnel license, ~~or EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification~~ when: (3-29-12)()

a. A peer review team recommends ~~license or certificate~~ revocation; or (3-29-12)()

b. The license ~~or certificate~~ holder is found to no longer be eligible for criminal history clearance per IDAPA 16.05.06, "Criminal History and Background Checks." (3-29-12)()

c. ~~Decisions to revoke an EMS personnel license will be reviewed by the Idaho EMS Physician Commission at the Commission's next available meeting.~~ The EMS Bureau will notify the city, fire district, hospital district, ambulance district, dispatch center, and county in which an EMS agency provides emergency prehospital response upon revocation of an EMS agency license. (3-29-12)()

~~07. Revoke EMS Agency License. The EMS Bureau may revoke an EMS agency license when: (3-29-12)~~

~~a. A peer review team recommends license revocation; (3-29-12)~~

~~b. The EMS Bureau will notify the city, fire district, hospital district, ambulance district, dispatch center, and county in which the EMS agency provides emergency prehospital response that the EMS Bureau is considering license revocation. (3-29-12)~~

06. Review of Administrative Actions by the EMS Physician Commission. The EMS Physician Commission must review, at their next available meeting, administrative actions taken by the Department as described in Subsections 330.01 through 330.05 of this rule. ()

331. -- 339. (RESERVED)

340. VIOLATIONS THAT MAY RESULT IN FINES BEING IMPOSED ON EMS AGENCY.

In addition to administrative license actions provided in Section 56-1022, Idaho Code, and these rules, a fine may be imposed by the EMS Bureau upon recommendation of a peer review team on a licensed EMS agency as a consequence of agency violations. Fines may be imposed for the following violations: (3-29-12)

01. Operating An Unlicensed EMS Agency. Operating without a license required in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," including: (7-1-14)

a. Failure to obtain an initial license; (3-29-12)

b. Failure to obtain a license upon change in ownership; or (3-29-12)

c. Failure to renew a license and continues to operate as an EMS agency. (3-29-12)

02. Unlicensed Personnel Providing Patient Care. Allowing an unlicensed individual to provide patient care without first obtaining an EMS personnel license required in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," at the appropriate level for the EMS agency. (3-29-12)

03. Failure to Respond. Failure of the EMS agency to respond to a 911 request for service within the agency primary response area in a typical manner of operations when dispatched to a medical illness or injury, under licensure requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," except when the responder reasonably determines that: (7-1-14)

a. There are disaster conditions; (3-29-12)

- b. Scene safety hazards are present or suspected; or (3-29-12)
- c. Law enforcement assistance is necessary to assure scene safety, but has not yet allowed entry to the scene. (3-29-12)

04. Unauthorized Response by EMS Agency. Responding to a request for service which deviates from or exceeds those authorized by the EMS agency license requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." (7-1-14)

05. Failure to Allow Inspections. Failure to allow the EMS Bureau or its representative to inspect the agency facility, equipment, records, and other licensure requirements provided in IDAPA 16.021.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." (3-29-12)()

06. Failure To Correct Unacceptable Conditions. Failure of the EMS agency to correct unacceptable conditions within the time frame provided in a negotiated resolution settlement, or a warning letter issued by the EMS Bureau. Including the following: (3-29-12)

- a. Failure to maintain an EMS vehicle in a safe and sanitary condition; (3-29-12)
- b. Failure to have available minimum EMS Equipment; (3-29-12)
- c. Failure to correct patient or personnel safety hazards; or (3-29-12)
- d. Failure to retain an EMS agency medical director: (3-29-12)

07. Failure to Report Patient Care Data. Failure to submit patient care data as required in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." (7-1-14)

(BREAK IN CONTINUITY OF SECTIONS)

350. REINSTATEMENT ~~OF EMS LICENSE~~ FOLLOWING REVOCATION.

An application of any revoked ~~EMS agency or personnel~~ license, certificate, or educational program approval, may be filed with the EMS Bureau no earlier than one (1) year from the date of the ~~license~~ revocation. (3-29-12)()

01. Peer Review for Reinstatement. The EMS Bureau will conduct a peer review to consider the reinstatement application. (3-29-12)

02. Recommendation of Peer Review Team. The peer review team will make a recommendation to the EMS Bureau to accept or reject the application for reinstatement. (3-29-12)

03. Reinstatement Determination. The EMS Bureau will accept or reject the reinstatement application based on the peer review team recommendation and other extenuating circumstances. (3-29-12)

a. Reinstatement of a revoked EMS personnel license is subject to the lapsed license reinstatement requirements in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." (3-29-12)

b. Reinstatement of a revoked EMS agency license will be subject to an initial agency application requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." (7-1-14)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.02.02 - RULES OF THE IDAHO EMERGENCY MEDICAL SERVICES
(EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1013A and 56-1023, Idaho Code.

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

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 236 and 237](#).

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

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Wayne Denny at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1013A and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

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

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted and deemed not feasible because the content of the proposed updates to the EMS Physician Commission Standards Manual already represents extensive input from stakeholders gathered on an ongoing basis during 2015.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2016-1, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being published in this chapter of rules due to its length and format, but it is available upon request from Idaho EMS.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 28th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0202-1501

004. INCORPORATION BY REFERENCE.

The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~5~~⁶-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the Internet at www.emspc.dhw.idaho.gov or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID, 83712-8249, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036. ~~(7-1-15)~~ ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.03 - EMERGENCY MEDICAL SERVICES

DOCKET NO. 16-0203-1501 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This action is authorized pursuant to Section 56-1023, Idaho Code.

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

The Emergency Medical Services (EMS) chapter of rules is being repealed in its entirety.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 99 and 100](#).

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Bruce Cheeseman at (208) 334-4000.

DATED this 25th Day of November, 2015.

Tamara Prisock
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This action is authorized pursuant to Section 56-1023, Idaho Code.

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

Tuesday, August 11, 2015 - 10:00 a.m. MDT

2224 East Old Penitentiary Road
Boise, ID 83712

PARTICIPATION BY WEBINAR
(for those who are unable to attend the hearing)

To join the webinar, go to:
<https://global.gotomeeting.com/join/553709749>

Use your microphone and speakers (VoIP) -- a headset is recommended. Or, call in using your telephone.

Dial: 1 (646) 749-3122
Access Code: 553-709-749

Audio PIN: Shown after joining the meeting using URL above
Meeting ID: 553-709-749

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

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

The Emergency Medical Services (EMS) chapter of rules is being repealed in its entirety. Over the past several years, the Department has been working on rewriting the rules governing EMS in Idaho. As new chapters of rules have been written, the corresponding, obsolete portions of the EMS chapter (IDAPA 16.02.03) were deleted. The few rules remaining in the old chapter are being moved into the new EMS education chapter (proposed as IDAPA 16.01.05). As a result, the chapter can now be repealed.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

The Emergency Medical Services (EMS) program is funded through dedicated funds. This rulemaking has no fiscal impact to those funds or to the state general fund. This rulemaking is intended to be cost-neutral.

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 three (3) times: in the March 4, 2015, Idaho Administrative Bulletin, **Vol. 15-3, pages 13-15**; the April 1, 2015, Idaho Administrative Bulletin, **Vol. 15-4, pages 28-30**; and the May 6, 2015, Idaho Administrative Bulletin, **Vol. 15-5, pages 53-54**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

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

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0203-1501

IDAPA 16.02.03 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.02.19 - FOOD SAFETY AND SANITATION STANDARDS FOR FOOD ESTABLISHMENTS (THE IDAHO FOOD CODE)

DOCKET NO. 16-0219-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 37-121 and 39-1603, Idaho Code.

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

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 2, 2015, Idaho Administrative Bulletin, [Vol. 15-9, pages 88 through 102](#). Based on comments received on the proposed rules, amendments have been made for clarification of farmers markets, roadside stands, and agricultural markets.

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

This rulemaking has no fiscal impact to state general funds or any other funds.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, documents have been incorporated by reference into these rules to give them the force and effect of law. The document is "Food Code, 2013 Recommendations of the United States Public Health Service Food and Drug Administration," Publication PB2013-110462. The document currently incorporated in these rules, is being updated from the 2001 edition to the 2013 edition.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Patrick Guzzle 208-334-5936.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-3505, and 56-1005, Idaho Code.

MEETING SCHEDULE: Public hearings on the proposed rulemaking will be held at the following locations. All times listed are local time:

Tuesday, September 8, 2015 3:00 pm & 5:00 pm	Wednesday, September 9, 2015 3:00 pm & 5:00 pm	Thursday, September 10, 2015 1:00 pm & 3:00 pm
Panhandle Health Dist. Office Conference Room 322 Marion Sandpoint, ID 83864	Panhandle Health Dist. Office Shoshone Room 8500 N. Atlas Drive Hayden, ID 83885	Public Health - Idaho North Central Dist. Office Conference Room 333 E. Palouse River Drive Moscow, ID 83843
Friday, September 11, 2015 1:00 pm & 3:00 pm	Monday, September 14, 2015 3:00 pm	Tuesday, September 15, 2015 1:00 pm & 7:00 pm
Public Health - Idaho North Central District Large Conference Room 215 10th Street Lewiston, ID 83501	Southeastern Idaho Public Health Conference Rooms 1 & 2 1910 Alvin Ricken Drive Pocatello, ID 83201	Central District Health Dept. Syringa Room 707 N. Armstrong Place Boise, ID 83704
Tuesday, September 15, 2015 10:00 am & 3:00 pm	Tuesday, September 15, 2015 2:00 pm	Tuesday, September 15, 2015 3:00 pm
Southwest District Health Office Community Room 13307 Miami Lane Caldwell, ID 83607	South Central Public Health District Katz B Conference Room 1020 Washington St. N. Twin Falls ID 83301	Eastern Idaho Public Health South Conference Room 1250 Hollipark Drive Idaho Falls, ID 83401

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

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

These proposed rules update the current Idaho Food Code to better reflect industry practices and current food safety standards. This proposed rule incorporates, by reference, the 2013 FDA Model Food Code. Also included in these proposed rules is specific language that clarifies the status of “cottage food” operations in Idaho.

Based on comments that have been received during the negotiated rulemaking meetings, the proposed updates to the Idaho Food Code have been modified and include the following:

1. Clarification of definitions that have caused confusion;

2. Clarification of “cottage food operations” and a list of specific foods considered “cottage foods products;” and
3. Clarification of necessary requirements for producers of “acidified foods.”

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

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

This rulemaking has no fiscal impact to state general funds or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking published in the April 1, 2015, Idaho Administrative Bulletin, [Volume 15-4, pages 33 - 35](#), and May 6, 2015, Idaho Administrative Bulletin, [Volume 15-5, pages 57 and 58](#).

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, documents have been incorporated by reference into these rules to give them the force and effect of law. The document is “Food Code, 2013 Recommendations of the United States Public Health Service Food and Drug Administration,” Publication PB2013-110462. The document currently incorporated in these rules, and is being updated from the 2001 edition to the 2013 edition.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Patrick Guzzle at (208) 334-5936.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2015.

DATED this 13th Day of August, 2015.

LSO Rules Analysis Memo

Italicized red text that is double underscored is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0219-1501

001. TITLE, SCOPE AND APPLICABILITY.

01. Title. The title of this chapter is IDAPA 16.02.19, “Food Safety and Sanitation Standards for Food Establishments,” and may also be known as “The Idaho Food Code.” (4-6-05)

02. Scope. The purpose of these rules is to establish standards for the provision of safe, unadulterated and honestly presented food for consumption by the public. These rules provide requirements for licensing, inspections, review of plans, employee restriction, and license suspensions for food establishments and food processing plants. Also included are definitions and set standards for management, personnel, food operations, equipment and facilities. (4-6-05)

03. These Rules Apply to Food Establishments. Food establishments as defined in Section 39-1602, Idaho Code must follow these rules. Those facilities include but are not limited to the following: (4-6-05)

a. Restaurants, catering facilities, taverns, kiosks, vending facilities, commissaries, cafeterias, mobile food facilities, temporary food facilities; and (4-6-05)

b. Schools, senior centers, hospitals, residential care and treatment facilities, nursing homes, correctional facilities, camps, food banks, and church facilities; and (4-6-05)

c. Retail markets, meat, fish, delicatessen, bakery and supermarkets, convenience stores, health food stores, and neighborhood markets; and (4-6-05)

d. Food, water and beverage processing and bottling facilities that manufacture, process and distribute food, water and beverages within the state of Idaho, and are not inspected for food safety by a federal agency. (4-6-05)

04. These Rules Do Not Apply to These Establishments. These rules do not apply to the following establishments as exempted in Idaho Code. (4-6-05)

a. Agricultural markets as exempted in Section 39-1602, Idaho Code. (4-6-05)

b. Bed-and-breakfast operations that prepare and offer food for breakfast only to guests. The number of guest beds must not exceed ten (10) beds as defined in Section 39-1602, Idaho Code. (4-6-05)

c. Day care facilities regulated by Sections 39-1101 through 39-1119, Idaho Code. (4-6-05)

d. Licensed outfitters and guides regulated by Sections 36-2101 through 36-2119, Idaho Code. (4-6-05)

e. Low-risk food establishments, as exempted in Section 39-1602, Idaho Code, which offer only ~~non-potentially hazardous~~ non-time/temperature control for safety (non-TCS) foods. ~~(4-6-05)~~ ()

f. Farmers market vendors and roadside stands that only offer or sell non-time/temperature control for safety (non-TCS) foods or cottage foods. ()

fg. Non-profit charitable, fraternal, or benevolent organizations that do not prepare or serve food on a regular basis as exempted in Section 39-1602, Idaho Code. Food is not considered to be served on a regular basis if it is not served for more than five (5) consecutive days on no more than three (3) occasions per year for foods which are ~~not potentially hazardous~~ non-time/temperature control for safety (non-TCS). For all other food, it must not be served more than one (1) meal per week. ~~(4-6-05)~~ ()

gh. Private homes where food is prepared or served for family consumption or receives catered or home-delivered food as exempted by Section 39-1602, Idaho Code. (4-6-05)

i. Cottage food operations, when the consumer is informed and must be provided contact information for the cottage food operations as follows: ()

i. By a clearly legible label on the product packaging; or a clearly visible placard at the sales or service location that also states: ()

ii. The food was prepared in a home kitchen that is not subject to regulation and inspection by the regulatory authority; and ()

iii. The food may contain allergens. ()

05. How to Use This Chapter of Rules. The rules in this chapter are modifications, additions or deletions made to the federal publication incorporated by reference in Section 004 of these rules. In order to follow these rules the publication is required. Changes to those standards are listed in this chapter of rules by listing which section of the publication is being modified at the beginning of each section of rule. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

004. INCORPORATION BY REFERENCE.

The Department is adopting by reference the "Food Code, 2011³ Recommendations of the United States Public Health Service Food and Drug Administration," ~~published by National Technical Information Service, Publication PB2002-100819~~ PB2013-110462. A certified copy of this publication may be reviewed at the main office of the Department of Health and Welfare. It is also available online at ~~<http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2001/default.htm>~~ <http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm374275.htm>. This publication is being adopted with modifications and additions as follows: (4-6-05)()

01. Chapter 1, Purpose and Definitions. Additions and modifications have been made to this chapter. See Sections 100 - 199 of these rules. (4-6-05)

02. Chapter 2, Management and Personnel. Modifications have been made to this chapter. See Sections 200 - 299 of these rules. (4-6-05)

03. Chapter 3, Food. Modifications have been made to this chapter. See Sections 300-399 of these rules. (4-6-05)

04. Chapter 4, Equipment, Utensils, and Linens. This chapter has been adopted with no modifications. (4-6-05)

05. Chapter 5, Water, Plumbing and Waste. This chapter has been adopted with no modifications. (4-6-05)

06. Chapter 6, Physical Facilities. Modifications have been made to ~~this chapter has been adopted with no modifications.~~ See Sections 600-699 of these rules. (4-6-05)()

07. Chapter 7, Poisonous or Toxic Materials. Modifications have been made in this chapter. See Sections 700 - 799 of these rules. (4-6-05)

08. Chapter 8, Compliance and Enforcement. Modifications have been made in this chapter. See Sections 800-899 of these rules. (4-6-05)

09. Annexes 1 Through 7 Are Excluded. These sections have not been adopted. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

Any disclosure of information obtained by the Department is subject to the restrictions in Title 74, Chapter 1, Idaho Code. Restrictions contained in Section 39-610, Idaho Code, and the Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records," must also be followed. (4-6-05)

01. Contested Hearing and Appeal Records. All contested case hearings are open to the public, unless ordered closed at the discretion of the hearing officer based on compelling circumstances. A party to a hearing must maintain confidentiality of discussions that warrant closing the hearing to the public. (4-6-05)

02. Inspection Report. A completed inspection report is a public document and is available for public disclosure to any person who requests the report as provided in Idaho's Public Records Law, Title 74, Chapter 1, Idaho Code. (4-6-05)

03. Medical Records. Medical information given to the Department or regulatory authority will be confidential and must follow IDAPA 16.05.01, "Use And Disclosure of Department Records." (4-6-05)

04. Plans and Specifications. Plans and specifications submitted to the regulatory authority as required in Chapter 8 of the 20~~01~~¹³ Food Code referenced in Section 004 of these rules, must be treated as confidential or trade secret information under Section 74-107, Idaho Code. (4-6-05)()

(BREAK IN CONTINUITY OF SECTIONS)

100. PURPOSES AND DEFINITIONS.

Sections 100 through 199 of these rules will be used for modifications and additions to Chapter 1 of the 20~~01~~¹³ Food Code as incorporated in Section 004 of these rules. (4-6-05)()

101. -- 109. (RESERVED)

110. DEFINITIONS AND ABBREVIATIONS -- A THROUGH K.

The definitions defined in this section are modifications or additions to the definitions ~~given~~ and terms provided in the 20~~01~~¹³ Food Code. (4-6-05)()

01. Agricultural Market. ~~Any fixed or mobile retail food establishment engaged in the sale of raw or fresh fruits, vegetables and nuts in the shell. It may also include the sale of factory sealed non-potentially hazardous foods.~~ Any venue where a fixed or mobile retail food establishment can engage in the sale of raw or fresh fruits, vegetables, and nuts in the shell. It may also include the sale of factory sealed non-time/temperature control for safety foods (non-TCS). Agricultural market means the same as "farmers market" or "roadside stand." (4-6-05)()

02. Board. The State of Idaho Board of Health and Welfare as established in Section 56-1005, Idaho Code. (4-6-05)

03. Commissary. A commissary is a place where food containers or supplies are stored, prepared, or packaged for transit, sale, or service at other locations. ()

04. Consent Order. A consent order is an enforceable agreement between the regulatory authority and the license holder to correct violations that caused the actions taken by the regulatory authority. (4-6-05)

05. Core Item. Modifications to Section 1-201.10(B) by amending the term "core item" to mean the same as "non-critical item." ()

06. Cottage Food Operation. A cottage food operation is when a person or business prepares or produces cottage food products in the home kitchen of that person's primary residence or other designated kitchen or location. ()

07. Cottage Food Product. Cottage food products are non-time/temperature control for safety (non-TCS) foods that are sold directly to a consumer. Examples of cottage foods may include but are not limited to: baked goods, fruit jams and jellies, fruit pies, breads, cakes, pastries and cookies, candies and confections, dried fruits, dry herbs, seasonings and mixtures, cereals, trail mixes and granola, nuts, vinegar, popcorn and popcorn balls, and cotton candy. ()

08. Critical Item. A provision of this code that if in noncompliance, is more likely than other violations to contribute to food contamination, illness, or environmental health hazard. A critical item includes items with a quantifiable measure to show control of hazards such as but not limited to, cooking, reheating, cooling, and hand washing. Critical item means the same as "priority item." Critical item is an item that is denoted with a superscript (P). ()

09. Department. The Idaho Department of Health and Welfare as established in Section 56-1002, Idaho Code. (4-6-05)

~~05~~**10.** **Director.** The Director of the Idaho Department of Health and Welfare as established in Section 56-1003, Idaho Code. (4-6-05)

~~06~~**11.** **Embargo.** An action taken by the regulatory authority that places a food product or equipment used in food production on hold until a determination is made on the product's safety. (4-6-05)

~~07~~**12.** **Enforcement Inspection.** An inspection conducted by the regulatory authority when compliance with these rules by a food establishment is lacking and violations remain uncorrected after the first follow-up inspection to a routine inspection. (4-6-05)

13. **Farmers Market.** Any fixed or mobile retail food establishment at which farmer producers sell agricultural products directly to the general public. Farmers market means the same as "agricultural market" and "roadside stand." ()

~~08~~**14.** **Food Establishment.** Modifications to Section 1-201.10(36) ~~by deleting Section 1-201.10(36)(c)(iii)~~ amends the definition of "food establishment" as follows: (4-6-05)()

a. Delete Subparagraph 3(c) of the term "food establishment" in the 2013 Food Code; ()

b. Add Subparagraph 3(h) to the term "food establishment" to clarify that a cottage food operation is not a food establishment. ()

~~09~~**15.** **Food Processing Plant.** Modification to Section 1-201.10(37) ~~by deleting Section 1-201.10(37)(b)~~ amends the definition of "food processing plant" by deleting Subparagraph 2 of the term "food processing plant" in the 2013 Food Code. (4-6-05)()

~~10~~**6.** **High-Risk Food Establishment.** A high-risk food establishment does the following operations: (4-6-05)

a. Extensive handling of raw ingredients; (4-6-05)

b. Preparation processes that include the cooking, cooling and reheating of ~~potentially hazardous~~ time/temperature control for safety (TCS) foods; or (4-6-05)()

c. A variety of processes requiring hot and cold holding of ~~potentially hazardous~~ time/temperature control for safety (TCS) foods. (4-6-05)()

~~11~~**7.** **Intermittent Food Establishment.** An intermittent food establishment is ~~one~~ a food vendor that operates for a period of time, not to exceed three (3) days per week, at a single, specified location in conjunction with a recurring event and that offers time/temperature control for safety (TCS) foods to the general public. Examples of a recurring event may be a farmers' or community market, or a holiday market. An intermittent food establishment does not include the vendor of farm fresh ungraded eggs at a recurring event (4-2-08)()

111. DEFINITIONS AND ABBREVIATIONS -- L THROUGH Z.

The definitions defined in this section are modifications or additions to the definitions ~~given~~ and terms provided in the 2001~~3~~ Food Code. (4-6-05)()

01. **License.** The term "license" is used in these rules the same as the term "permit" is used in the 2001~~3~~ Food Code. (4-6-05)()

02. **License Holder.** The term "license holder" is used in these rules the same as the term "permit holder" is used in the 2001~~3~~ Food Code. (4-6-05)()

03. **Low-Risk Food Establishment.** A low-risk food establishment provides factory-sealed pre-packaged ~~non-potentially hazardous~~ non-time/temperature control for safety (non-TCS) foods. The establishment may have limited preparation of ~~non-potentially hazardous~~ non-time/temperature control for safety (non-TCS) foods

only.

~~(4-6-05)~~()

04. Medium-Risk Food Establishment. A medium-risk food establishment includes the following: (4-6-05)

a. A limited menu of one (1) or two (2) items; or (4-6-05)

b. Pre-packaged raw ingredients cooked or prepared to order; or (4-6-05)

c. Raw ingredients requiring minimal assembly; or (4-6-05)

d. Most products are cooked or prepared and served immediately; or (4-6-05)

e. Hot and cold holding of ~~potentially hazardous~~ time/temperature control for safety (TCS) foods is restricted to single meal service. ~~(4-6-05)~~()

05. Mobile Food Establishment. A mobile food establishment is a food establishment selling or serving food for human consumption from any vehicle or other temporary or itinerant station and includes any movable food service establishment, truck, van, trailer, pushcart, bicycle, watercraft, or other movable food service with or without wheels, including hand-carried, portable containers in or on which food or beverage is transported, stored, or prepared for retail sale or given away at temporary locations. ()

06. Non-Critical Item. A non-critical item is a provision of this Code that is not designated as a critical item or potentially-critical item. A non-critical item includes items that usually relate to general sanitation, operation controls, sanitation standard operating procedures (SSOPs), facilities or structures, equipment design, or general maintenance. Non-critical item means the same as CORE ITEM. ()

07. Potentially-Critical Item. A potentially-critical item is a provision in this Code whose application supports, facilitates, or enables one (1) or more critical items. Potentially critical item includes an item that requires the purposeful incorporation of specific actions, equipment, or procedures by industry management to attain control of risk factors that contribute to foodborne illness or injury such as personnel training, infrastructure or necessary equipment, HACCP plans, documentation or record keeping, and labeling. Potentially-critical item means the same as priority foundation item. A potentially-critical item is an item that is denoted in this code with a superscript (Pf). ()

08. Priority Item. Modification to Section 1-201.10(B) by amending the term “priority item” to read priority item means the same as critical item. ()

09. Priority Foundation Item. Modification to Section 1-201.10(B) by amending the term “priority foundation item” to read priority foundation item means the same as potentially-critical item. ()

105. Regulatory Authority. The Department or its designee is the regulatory authority authorized to enforce compliance of these rules. (4-6-05)

a. The Department is responsible for preparing the rules, rule amendments, standards, policy statements, operational procedures, program assessments and guidelines. (4-6-05)

b. The seven (7) Public Health Districts and the ~~Bureau of Facility Standards~~ Division of Licensing and Certification have been designated by the Director as the regulatory authority for the purpose of issuing licenses, collecting fees, conducting inspections, reviewing plans, determining compliance with the rules, investigating complaints and illnesses, examining food, embargoing food and enforcing these rules. ~~(4-6-05)~~()

0611. Risk Control Plan. Is a document describing the specific actions to be taken by the license holder to address and correct a continuing hazard or risk within the food establishment. (4-6-05)

12. Roadside Stand. Any fixed or mobile retail food establishment at which an individual farmer producer sells own agricultural products directly to consumers. Roadside stand means the same as “agricultural

market” and “farmers market.” ()

112. -- 199. (RESERVED)

200. MANAGEMENT AND PERSONNEL.

Sections 200 through 299 of these rules will be used for modifications and additions to Chapter 2 of the 2001 Food Code as incorporated in Section 004 of these rules. (4-6-05) ()

(BREAK IN CONTINUITY OF SECTIONS)

210. DEMONSTRATION OF KNOWLEDGE.

Modification to Section 2-102.11. The person in charge of a food establishment may demonstrate knowledge on the risks of foodborne illness or health hazards by one (1) of the following. (4-6-05)

01. No Critical Violations. Complying with the 2001 Food Code by not having any critical violations at the time of inspection; or (4-6-05) ()

~~**02. Certification.** Being a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program; or~~ (4-6-05)

~~**03. Time of Inspection Interview.** Responding correctly to the inspector's questions as they relate to the specific food operations as listed in Section 2-102.11(C) of the 2001 Food Code as incorporated in Section 004 of these rules; or~~ (4-6-05)

~~**04. Approved Courses.** Completion of the Idaho Food Safety and Sanitation Course, or an equivalent course designed to meet the same training as the Idaho Food Safety and Sanitation Course.~~ (4-6-05)

03. Certified Food Protection Manager. Modification to Section 2-102.12(A). Beginning July 1, 2018, at least one employee that has supervisory and management responsibility and the authority to direct and control food preparation and service must be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program. ()

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

~~**220. EMPLOYEE HEALTH.**~~

~~**01. Reporting of Norovirus.** Addition to Section 2-201.11. The addition of Norovirus to illnesses required to be reported.~~ (4-2-08)

~~a. A person diagnosed or ill with Norovirus within the past forty-eight (48) hours is required to report the illness to the person in charge.~~ (4-2-08)

~~b. A food employee, who lives in the same household and has knowledge of a person who is diagnosed with Norovirus, is required to report that information to the person in charge.~~ (4-2-08)

~~**02. Exclusion and Restrictions.** Addition to Section 2-201.12. In addition, the person in charge of a food establishment must:~~ (4-2-08)

~~a. Notify the regulatory authority to obtain guidance on proper actions needed to protect the public if there is reason to suspect that any employee has a disease that is communicable through food as listed in IDAPA 16.02.10, “Idaho Reportable Diseases”;~~ (4-2-08)

~~b. Exclude a food employee diagnosed with an infection from Norovirus when symptomatic;~~ (4-2-08)

~~c. Restrict a food employee diagnosed with an infection from Norovirus when asymptomatic; and~~

~~(4-2-08)~~

~~d. Exclude a food employee diagnosed with an infection from Norovirus whether symptomatic or asymptomatic when serving a highly susceptible population. (4-2-08)~~

~~03. **Removal of Exclusion and Restrictions.** Addition to Section 2-201.13. In addition, the person in charge may remove an employee diagnosed with Norovirus from restriction or exclusion when one (1) of the following conditions is met: (4-2-08)~~

~~a. Written medical documentation is provided from a licensed medical practitioner; (4-2-08)~~

~~b. Forty-eight (48) hours have passed since the employee became asymptomatic; or (4-2-08)~~

~~c. Employee did not develop symptoms and more than forty-eight (48) hours have passed since the employee was diagnosed with Norovirus. (4-2-08)~~

~~221. -- 299. (RESERVED)~~

300. FOOD.

Sections 300 through 399 of these rules will be used for modifications and additions to Chapter 3 of the 2001¹³ Food Code as incorporated in Section 004 of these rules. ~~(4-6-05)()~~

(BREAK IN CONTINUITY OF SECTIONS)

~~326. -- 349. (RESERVED)~~

~~350. **TEMPERATURE REQUIREMENTS.**~~

~~Modifications are being made to the temperature guidelines in the following sections of the 2001 Food Code.~~

~~(4-6-05)~~

~~01. **Specifications for Receiving Potentially Hazardous Food.** Modification to Section 3-202.11(D). Food that is cooked to a temperature and for a time specified under Sections 3-401.11 through 3-401.13 and received hot, must be at a temperature of 57°C (135°F) or above. (4-6-05)~~

~~02. **Preventing Contamination from In-Use Utensils, Between-Use Storage.** Modification to Section 3-304.12(F). In a container of water, if the water is maintained at a temperature of at least 57°C (135°F) and the container is cleaned at a frequency specified under Subparagraph 4-602.11(D)(7). (4-6-05)~~

~~03. **Plant Food Cooking for Hot Holding.** Modification to Section 3-401.13. Fruits and vegetables that are cooked for hot holding must be cooked to a temperature of 57°C (135°F). (4-6-05)~~

~~04. **Reheating for Hot Holding Ready to Eat Food.** Modification to Section 3-403.11(C). Food taken from a commercially processed hermetically sealed container, or from an intact package from a food processing plant that is inspected by the food regulatory authority that has jurisdiction of the plant, must be heated to a temperature of at least 57°C (135°F) for hot holding. (4-6-05)~~

~~05. **Cooling Cooked Potentially Hazardous Food.** Modification to Section 3-501.14(A). Cooked potentially hazardous food must be cooled: (4-6-05)~~

~~a. Within two (2) hours from 57°C (135°F) to 21°C (70°F); and (4-6-05)~~

~~b. Within six (6) hours from 57°C (135°F) to 5°C (41°F) or less, or to 7°C (45°F) or less as specified under Section 3-501.16(A)(2)(b) provided the food is cooled from 57°C (135°F) to 21°C (70°F) within the first two (2) hours. (4-6-05)~~

~~06. Potentially Hazardous Food, Hot and Cold Holding. Modification to Section 3-501.16(A)(1). Potentially hazardous food must be maintained at 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified under Section 3-401.11(B) or reheated as specified in Section 3-403.11(E) may be held at a temperature of 54°C (130°F).~~ (4-6-05)

~~351. VARIANCE REQUIREMENTS FOR FOOD ESTABLISHMENTS. Modifications to Section 3-502.11. Sections 3-502.11(E) and (F), are not adopted.~~ (4-6-05)

~~352.~~ 354. (RESERVED)

355. FOOD PROCESSING PLANTS.

Food processing plants, establishments, canning factories or operations must meet the requirements in Chapters 1 through 8 of the 2001 Food Code, and Subsections 355.01 through 355.057 of these rules. (4-6-05)()

01. Thermal Processing of Low-Acid Foods. Low-acid food products processed using thermal methods for canning must meet the requirements of 21 CFR 113. (4-6-05)

~~114.~~ **02. Processing of Acidified Foods.** Acidified food products must meet the requirements of 21 CFR ()

~~023.~~ **Bottled Water Processing.** Bottled drinking water processed in Idaho must be from a licensed processing facility that meets the requirements of 21 CFR 129. Bottled drinking water must also meet the quality and monitoring requirements in 21 CFR 165. (4-6-05)

~~034.~~ **Approval of Process Methods.** A variance by the regulatory authority must be approved and granted for specialized processing methods for products listed in Section 3-502.11. (4-6-05)

~~045.~~ **Labels.** Proposed labels must be submitted to the regulatory authority for review and approval before printing. (4-6-05)

~~056.~~ **Testing.** The license holder is responsible for chemical, microbiological or extraneous material testing procedures to identify failures or food contamination of food products being processed or manufactured by the license holder. (4-6-05)

~~067.~~ **Quality Assurance Program.** The license holder or his designated person must develop and submit to the regulatory authority for review and approval a quality assurance program or HACCP plan which covers the food processing operation. The program must include the following: (4-6-05)

- a. An organization chart identifying the person responsible for quality control operations; (4-6-05)
- b. A process flow diagram outlining the processing steps from the receipt of the raw materials to the production and packaging of the finished product(s) or group of related products; (4-6-05)
- c. A list of specific points in the process which are critical control points that must have scheduled monitoring; (4-6-05)
- d. Product codes that establish and identify the production date and batch; (4-6-05)
- e. A manual covering sanitary maintenance of the facility and hygienic practices to be followed by the employees; and (4-6-05)
- f. A records system allowing for review and evaluation of all operations including the quality assurance program results. These records must be kept for a period of time that exceeds the shelf life of the product by six (6) months or for two (2) years, whichever is less. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

600. PHYSICAL FACILITIES.

Sections 600 through 699 of these rules will be used for modifications and additions to Chapter 6 of the 20~~01~~¹³ Food Code as incorporated in Section 004 of these rules. (4-6-05)()

601. -- 619. (RESERVED)

620. PRIVATE HOMES AND LIVING OR SLEEPING QUARTERS, USE PROHIBITION.

Modifications to Section 6-202.111. ~~4~~ Except for cottage food operations, a private home, a room used as living or sleeping quarters, or an area directly opening into a room used as living or sleeping quarters may not be used for conducting food establishment operations. Residential care or assisted living facilities designed to be a homelike environment, are exempted from Section 6-202.111. (4-6-05)()

621. -- 699. (RESERVED)

700. POISONOUS OR TOXIC MATERIALS.

Sections 700 through 799 of these rules will be used for modifications and additions to Chapter 7 of the 20~~01~~¹³ Food Code as incorporated in Section 004 of these rules. (4-6-05)()

(BREAK IN CONTINUITY OF SECTIONS)

800. COMPLIANCE AND ENFORCEMENT.

Sections 800 through 899 of these rules will be used for modifications and additions to Chapter 8 of the 20~~01~~¹³ Food Code as incorporated in Section 004 of these rules. (4-6-05)()

801. -- 829. (RESERVED)

830. APPLICATION FOR A LICENSE.

01. To Apply for a Food Establishment License. To apply for an Idaho food establishment license, the application and fee is submitted to the "regulatory authority" as defined in Section 111 of these rules. (4-6-05)()

02. Food License Expiration. The license for an Idaho food establishment expires on December 31st of each year. (4-6-05)

03. Renewal of License. A renewal application and a license fee must be submitted to the regulatory authority by December 1st of each year for the next calendar year starting January 1st. (4-6-05)

04. Summary Suspension of License. A license may be immediately suspended under Section 831 of these rules. Reinstatement of a license after a summary suspension does not require a new application or fee unless the license is revoked. (4-6-05)

05. Revocation of License. When corrections have been made to a food establishment whose license has been revoked under Section 860 of these rules, a new application and fee must be submitted to the regulatory authority. (4-6-05)

06. License is Non-Transferable. A license may not be transferred when ownership changes according to Section 8-304.20, of the 20~~01~~¹³ Food Code. The new owner must apply for his own license. (4-6-05)()

831. SUMMARY SUSPENSION OF LICENSE.

The regulatory authority may summarily suspend a license to operate a food establishment when it determines an imminent health hazard exists. (4-6-05)

01. Reasons a Summary Suspension May Be Issued. When a food establishment does not follow the principles of food safety, or a foodborne illness is found, or an environmental health hazard exists and public safety cannot be assured by the continued operation of the food establishment, a summary suspension may be issued. The following are some reasons the regulatory authority may determine a summary suspension is necessary: (4-6-05)

- a. Inspection of the food establishment shows uncorrected critical violations; (4-6-05)
- b. Examination of food shows the food is unsafe; (4-6-05)
- c. Review of records shows that proper steps for food safety have not been met; (4-6-05)
- d. An employee working with food is suspected of having a disease that is communicable through food; or (4-6-05)
- e. An imminent health hazard exists. (4-6-05)

02. Prior Notification Is not Required for a Summary Suspension. Upon providing a written notice of summary suspension to the license holder or person in charge, the regulatory authority may suspend a food establishment's license without prior warning, notice of hearing, or hearing. (4-6-05)

03. Written Notice of Summary Suspension. The regulatory authority must give the license holder or person in charge a written notice when suspending a license. The notice must include the following: (4-6-05)

- a. The specific reasons or violations the summary suspension is issued for with reference to the specific section of the 20**013** Food Code which is in violation; ~~(4-6-05)~~ ()
- b. A statement notifying the food establishment its license is suspended and all food operations are to cease immediately; (4-6-05)
- c. The name and address of the regulatory authority representative to whom a written request for re-inspection can be made and who can certify the reasons for the suspension have been eliminated; (4-6-05)
- d. A statement notifying the food establishment of its right to an informal hearing with the regulatory authority upon submission of a written request within fifteen (15) days of receiving the summary suspension notice; and (4-6-05)
- e. A statement informing the food establishment that proceedings for revocation of its license will be initiated by the regulatory authority, if violations are not corrected. (4-6-05)
- f. The right to appeal to the Department as provided in Section 861 of these rules. (4-6-05)

04. Length of Summary Suspension. The suspension will remain in effect until the conditions cited in the notice of suspension no longer exist and their elimination has been confirmed by the regulatory authority during a re-inspection. (4-6-05)

05. Re-Inspection of Food Establishment. The regulatory authority will conduct a re-inspection of the food establishment within two (2) working days of receiving a written request stating the condition for the suspension no longer exists. (4-6-05)

06. Reinstatement of License. The regulatory authority will immediately reinstate the suspended license if the re-inspection determines the public health hazard no longer exists. The regulatory authority will provide a written notice of reinstatement to the license holder or person in charge. (4-6-05)

832. -- 839. (RESERVED)

840. INSPECTIONS AND CORRECTION OF VIOLATIONS.
Modification to Section 8-401.10. (4-6-05)

01. **Inspection Interval Section 8-401.10(A).** Except as specified in Section 8-401.10(C), the regulatory authority must inspect a food establishment at least once a year. (4-6-05)
02. **Section 8-401.10(B).** This section has not been adopted. (4-6-05)
03. **Section 8-401.10(C).** This section is adopted as published. (4-6-05)
04. **Section 8-405.11.** This section is adopted with the following modifications: ()
- a. **Delete Section 8-405.11(B)(1); and** ()
- b. **Amend Section 8-405-11(B)(2) to ten (10) calendar days after the inspection for the permit holder to correct critical or potentially-critical items or HACCP plan deviations.** ()

841. INSPECTION SCORES.

The regulatory authority must provide the license holder an inspection report with a total score indicating the number of critical item violations and the number of repeat critical violations added together. Repeat violations are those observed during the last inspection. The inspection report will also score the total number of ~~non-critical~~ **potentially-critical** violations and non-critical violations and the number of repeat ~~non-critical~~ **potentially-critical** violations and non-critical violations. These scores will be used to determine if a follow-up inspection or a written report of correction is needed to verify corrections have been made. (4-6-05)()

01. **Medium-Risk Food Establishment.** If the critical violations exceed three(3), or the ~~non-critical~~ **potentially-critical** violations exceed six (6), or non-critical violations exceed eight (8), an on-site follow-up inspection is required for verification of correction by the regulatory authority. (4-6-05)()

02. **High-Risk Food Establishment.** If the critical violations exceed five (5), or the ~~non-critical~~ **potentially-critical** violations exceed eight (8), or non-critical violations exceed eight (8), an on-site follow-up inspection is required for verification of correction by the regulatory authority. (4-6-05)()

03. **Written Violation Correction Report.** A written violation correction report by the license holder may be provided to the regulatory authority if the total inspection score of the food establishment does not exceed those listed in Section 845 of these rules. The report must be mailed within five (5) days of the correction date identified on the inspection report. (4-6-05)

842. -- 844. (RESERVED)

845. VERIFICATION AND DOCUMENTATION OF CORRECTION.

In addition to Section 8-405.20 of the 2001~~3~~ Food Code, the on-site follow-up inspection may not be required for verification of correction if the regulatory authority chooses to accept a written report of correction from the license holder. (4-6-05)()

01. **Written Report of Correction.** The regulatory authority may choose to accept a written report of correction from the license holder stating that specific violations have been corrected. The license holder must submit this report to the regulatory authority within five (5) days after the correction date identified on the inspection report. (4-6-05)

a. **Medium-risk food establishment.** If the critical violations do not exceed three (3), or the ~~non-critical~~ **potentially-critical** violations do not exceed six (6), or the non-critical violations do not exceed six (6), a follow-up inspection is not required for verification of correction. (4-6-05)()

b. **High-risk food establishment.** If the critical violations do not exceed five (5), or the ~~non-critical~~ **potentially-critical** violations do not exceed eight (8), or the non-critical violations do not exceed eight (8), a follow-up inspection is not required for verification of correction. (4-6-05)()

02. **Risk Control Plan.** The regulatory authority may require the development of a risk control plan as

verification of correction. The risk control plan must provide documentation on how the license holder will obtain long term correction of critical violations that are repeated violations, including how control will be monitored and who will be responsible. (4-6-05)

846. -- 849. (RESERVED)

850. ENFORCEMENT INSPECTIONS.

01. Follow-Up Inspection. If a follow-up inspection reveals that critical, potentially-critical, or non-critical violations identified on a previous inspection have not been corrected or still exist, an enforcement inspection may be made. (4-6-05)()

02. Written Notice. The license holder will receive written notice on the inspection form of the specific date for an enforcement inspection. This date must be within fifteen (15) days of the current or follow-up inspection. (4-6-05)

03. Enforcement Inspections on Consent Order. When a compliance conference results in a consent order and includes a compliance schedule to correct violations without further regulatory action, all inspections by the regulatory authority to satisfy the compliance schedule will be considered enforcement inspections until the next annual inspection. (4-6-05)

04. Regulatory Action. If the violations have not been corrected by the date of the enforcement inspection, regulatory action will be initiated to revoke the license issued to the food establishment. (4-6-05)

(BREAK IN CONTINUITY OF SECTIONS)

860. REVOCATION OF LICENSE.

The regulatory authority may revoke the license issued to a food establishment when the license holder fails to comply with these rules or the operation of the food establishment is a hazard to public health. (4-6-05)

01. Reasons a License May Be Revoked. (4-6-05)

a. The license holder violates any term or condition in Section 8-304.11 of the 2001~~1~~³ Food Code. (4-6-05)()

b. Access to the facility is denied or obstructed by an employee, agent, contractor or other representative during the performance of the regulatory authority's duties. It is not necessary for the regulatory authority to seek an inspection order to gain access as permitted in Section 8-402.40 of the 2001~~1~~³ Food Code, before proceeding with revocation. (4-6-05)()

c. A public health hazard or critical violation remains uncorrected after being identified by the regulatory authority and an enforcement inspection confirms the violation or hazard still exists. See Section 850 of these rules on enforcement inspections. (4-6-05)

d. A non-critical violation remains uncorrected after being identified by the regulatory authority and an enforcement inspection confirms the violation still exists. See Section 845 of these rules on verification and documentation of correction. (4-6-05)

e. Failure to comply with any consent order issued after a compliance conference. See Section 861 of these rules on compliance conference. (4-6-05)

f. Failure to comply with a regulatory authority's summary suspension order. See Section 831 of these rules on summary suspension of a license. (4-6-05)

g. Failure to comply with an embargo order. See Section 851 of these rules on adulterated or

misbranded food.

(4-6-05)

h. Failure to comply with a regulatory authority order issued when an employee is suspected of having a communicable disease. See ~~Section 220 of these rules~~ **Chapter 2 of the 2013 Food Code** on employee health. ~~(4-6-05)~~()

02. Notice to Revoke a License. The regulatory authority must notify the license holder of the food establishment in writing of the intended revocation of the license. See Section 861 of these rules for appeal process. The notice must include ~~the~~ Subsections 860.02.a. through 860.02.c. of ~~these~~ **this** rules: ~~(4-6-05)~~()

a. The specific reasons and sections of the Idaho Food Code which are in violation and the cause for the revocation; and (4-6-05)

b. The right of the license holder to request in writing a compliance conference with the regulatory authority within fifteen (15) days of the notice; and (4-6-05)

c. The right of the license holder to appeal in writing to the Department of Health and Welfare. See Subsection 861.02 of these rules. (4-6-05)

d. The following is sufficient notification of the license holder's appeal rights: "You have the right to request in writing a compliance conference with (name and address of designated health district official) within fifteen (15) days of the receipt of this notice. You may also appeal the revocation of your license to the Director of the Department of Health and Welfare by filing a written appeal with the Department as provided in IDAPA 16.05.03, "Rules Governing Contested Case Proceeding and Declaratory Rulings," within fifteen (15) days of the receipt of this notice, or if a timely request is made for a compliance conference and the matter is not resolved by a consent order, within five (5) working days following the conclusion of the compliance conference." (4-6-05)

03. Effective Date of Revocation. The revocation will be effective fifteen (15) days following the date of service of notice to the license holder, unless an appeal is filed or a timely request for a compliance conference is made. If a compliance conference is requested and the matter is not resolved by a consent order, the revocation will be effective five (5) working days following the end of the conference, unless an appeal is filed with the Director of the Department of Health and Welfare within that time. See Section 861 of these rules for compliance conference, consent order and appeal process. (4-6-05)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.01 - ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also 42 CFR 435.

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

There are no changes being made in the pending rule aligning this chapter with federal regulations and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 238 through 241](#).

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:

The anticipated fiscal impact for FY 2017 for Transitional Medicaid will be \$9,771,060, with \$6,928,649 from federal funds and \$2,842,411 from state general funds. The fiscal impact amount was calculated using an estimation of the number of adults with children who will become eligible for Transitional Medicaid in FY 2017 multiplied by the current average monthly Medicaid claim by the Parent/Caretaker eligibility group.

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

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also 42 CFR 435.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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 the Medicare Access and CHIP Reauthorization Act of 2015, changes are being made to align this chapter of rules with federal regulations approved in that act. Transitional Medicaid (TM) previously thought to have a sunset clause was extended, and is being added. A change for eligibility for “authorized employment” is being removed to ensure eligibility determinations are correctly determined. Language is being removed that is not necessary for eligible institutions.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

The anticipated fiscal impact for FY 2017 for Transitional Medicaid will be \$9,771,060, with \$6,928,649 from federal funds and \$2,842,411 from state general funds. The fiscal impact amount was calculated using an estimation of the number of adults with children who will become eligible for Transitional Medicaid in FY 2017 multiplied by the current average monthly Medicaid claim by the Parent/Caretaker eligibility group.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Department has determined it was not feasible because changes are being made to align with federal regulations and to be in compliance with Idaho’s State Plan.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cheri Bourn at (208) 334-4934.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-1501

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.

To be eligible, an individual must be a lawfully present member of one (1) of the following groups: (3-20-14)

01. U.S. Citizen. A U.S. Citizen or a “national of the United States.” (3-20-14)

02. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is

considered a citizen if all of the following conditions are met: (3-20-14)

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (3-20-14)

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (3-20-14)

c. The child is under eighteen (18) years of age; (3-20-14)

d. The child is a lawful permanent resident; and (3-20-14)

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. (3-20-14)

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who is currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. (3-20-14)

04. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who was honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy, or U.S. Coast Guard for a reason other than their citizenship status, or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. (3-20-14)

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, who is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c), who remained continuously present in the U.S. until he became a qualified non-citizen. (3-20-14)

06. Non-Citizen Entering On or After August 22, 1996. A non-citizen who entered the U.S. on or after August 22, 1996, and who is: (3-20-14)

a. A refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from the date of entry; (3-20-14)

b. An asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date asylee status is assigned; (3-20-14)

c. An individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date deportation or removal was withheld; (3-20-14)

d. An Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or (3-20-14)

e. A Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act under Section 501(e) of P.L. 96-422 (1980), and can be eligible for seven (7) years from the date of entry. (3-20-14)

07. Qualified Non-Citizen Entering On or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), who entered the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. (3-20-14)

08. American Indian Born in Canada. An American Indian born in Canada, under 8 U.S.C. 1359. (3-20-14)

09. American Indian Born Outside the U.S. An American Indian born outside of the U.S., who is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). (3-20-14)

10. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. (3-20-14)

11. Victim of Severe Form of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (3-20-14)

a. Is under the age of eighteen (18) years; or (3-20-14)

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (3-20-14)

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (3-20-14)

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (3-20-14)

12. Afghan Special Immigrant. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007. (3-20-14)

13. Iraqi Special Immigrant. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. (3-20-14)

~~**14. Employment Authorized Alien.** An alien granted an employment authorization document (EAD), as defined in 8 CFR Part 274a.12(e). (3-20-14)~~

14. Individuals not Meeting the Citizenship or Qualified Non-Citizen Requirements. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 221.01 through 221.14³ of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. (3-20-14)()

(BREAK IN CONTINUITY OF SECTIONS)

412. -- 41⁹⁸. (RESERVED)

419. TRANSITIONAL MEDICAID FOR ADULTS.

Participants who no longer qualify for Medicaid due to an increase in earned income or working hours are eligible for an additional twelve (12) months of Medicaid. Participants must have been eligible for Medicaid during at least three (3) of the six (6) months immediately preceding the month in which the participant became ineligible. ()

(BREAK IN CONTINUITY OF SECTIONS)

532. RESIDENT OF AN ELIGIBLE INSTITUTION.

A resident of an eligible institution must meet all nonfinancial and financial criteria of Title XIX, ~~or~~ Title XXI, or any other applicable program. ~~Eligible institutions are medical institutions, intermediate care facilities, child care institutions for foster care, or publicly operated community residences serving no more than sixteen (16) residents.~~ (3-20-14)()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO
DOCKET NO. 16-0304-1501
NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-203, Idaho Code, 7 CFR 273.2(j), and 7 CFR 273.8(a).

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

This rulemaking aligns the Food Stamp rules with a federal requirement that excludes households from qualifying for a \$5000 resource limit when they are not in compliance with program participation requirements. The chapter is also being amended to clarify the language describing the effected households.

Specifically, this rulemaking lowers the food stamp applicant resource limit to \$2,250, or \$3,250 for certain households, and clarifies the description of such households.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 242 through 245](#).

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

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

There is no anticipated fiscal impact to the state general fund as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Malinda Reissig at (208) 334-5779.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-203, Idaho Code, 7 CFR 273.2(j), and 7 CFR 273.8(a).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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 aligned the Food Stamp rules with a federal requirement that excludes households from receiving the \$5000 resource limit when they are not in compliance with program participation requirements. The chapter is also being amended to clarify the language describing the effected households.

Specifically, this rulemaking reduces the food stamp applicant resource limit from \$5,000 to \$2,250, or \$3,250 for certain households, and clarifies the description of such households.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

There is no anticipated fiscal impact to the state general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rulemaking is simple in nature and aligns rules with federal limits.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Malinda Reissig at (208) 334-5779.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0304-1501

010. DEFINITIONS A THROUGH D.

For the Food Stamp Program, the following definitions apply: (4-11-06)

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

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

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

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

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

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

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

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

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

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

11. Broad Based Categorical Eligibility. If a participant meets the eligibility requirements found in 7 CFR Section 273.2(j)(2) as well as all other Food Stamp eligibility criteria, then the participant is eligible for Food Stamps. Participants who are eligible under this definition are also subject to resource, gross, and net income eligibility standards. ()

1~~2~~2. Categorical Eligibility. If all household members receive or are authorized to receive monthly cash payment through TAFI, AABD or SSI, the household is categorically eligible. Categorically eligible households are exempt from resource, gross and net income eligibility standards. (4-11-06)

1~~2~~3. Certification Determination. Actions necessary to determine household eligibility including interviews, verification, approval, denial, field investigation, analysis and corrective action necessary to insure prompt, efficient and correct certifications. (6-1-94)

1~~3~~4. Certification Period. The period of time a household is certified to receive Food Stamp benefits. The month of application counts as the first month of certification. (4-11-06)

1~~4~~5. Contact (Six-Month). A six-month contact is a recertification that waives the interview requirement, allowing for written contact and verification of the participant's circumstances in lieu of the interview. (3-29-12)

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

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

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

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

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

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

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

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

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

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

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

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

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

1920. Documentation. The method used to record information establishing eligibility. The information must sufficiently explain the action taken and the proof and how it was used. (6-1-94)

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

(BREAK IN CONTINUITY OF SECTIONS)

181. ~~(RESERVED)~~ BROAD BASED CATEGORICALLY ELIGIBLE HOUSEHOLD EXCEPTIONS.
If a household contains any of the following members, the household is not eligible under Broad Based Categorical Eligibility. ()

01. IPV. Any household member is disqualified for an Intentional Program Violation (IPV). ()

02. Drug-Related Felony. Any household member is ineligible because of a drug-related felony. ()

03. Strike. Any household member is on strike. ()
04. Transferred Resources. Any household member transferred resources in order to qualify for benefits. ()
05. Refusal to Cooperate. Any household member refused to cooperate in providing information that is needed to determine initial or ongoing eligibility. ()

(BREAK IN CONTINUITY OF SECTIONS)

305. RESOURCE LIMIT.

The Food Stamp resource limit is five thousand dollars (\$5,000) for Broad Based Categorically Eligible households. Households that do not meet the requirements for Broad Based Categorical Eligibility are subject to resource limits published by the USDA Food and Nutrition Service. ~~(4-7-11)~~()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

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

DOCKET NO. 16-0305-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective after review by the legislature, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

There are no changes to the pending rule regarding aligning with the current State Plan and the rule is being adopted as proposed. The complete text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 246 through 251](#).

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

The Department anticipates that the annual fiscal impact for changes to the pre-existing medical expenses will be \$403,600, with \$282,640 from federal funds and \$120,960 from state general funds. The fiscal impact amount is due to the Department's anticipation of an increase in the number of requests from participants for pre-existing medical expenses.

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

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

**THE FOLLOWING NOTICE WAS PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2015.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

The Aid to the Aged, Blind, and Disabled (AABD) program rules are being updated and aligned with the current State Plan that was approved by the Centers for Medicare and Medicaid Services (CMS) in January 2015. This change adds additional types of allowable pre-existing medical expenses towards a participant's liability.

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

CMS approved amendments to the State Plan that were effective in January 2015, and these changes provide a benefit to participants that adds additional pre-existing medical expenses allowed towards a participant's liability.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

The Department anticipates that the annual fiscal impact for changes to the pre-existing medical expenses will be \$403,600, with \$252,240 from federal funds and \$120,960 from state general funds. The fiscal impact amount is due to the Department's anticipation of an increase in the number of requests from participants for pre-existing medical expenses.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because these changes update the rules for amendments made to the State Plan that were approved in January 2015, by the Centers for Medicare and Medicaid Services (CMS) and not negotiable by the Department.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Callie Harrold (208) 334-0663.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 1st Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-1501

723. PATIENT LIABILITY FOR PERSON WITH NO COMMUNITY SPOUSE.

For a participant with no community spouse, patient liability is computed as described in Subsections 723.01 through 723.03 of this rule. (5-3-03)

01. Income of Participants in Long-Term Care. For a single participant, or participant whose spouse is also in long-term care and chooses the SSI method of calculating the amount of income and resources, the patient liability is his total income less the deductions in Subsection 723.03 of this rule. (5-3-03)

02. Community Property Income of Long-Term Care Participant with Long-Term Care Spouse. Patient liability income for a participant, whose spouse is also in long-term care, choosing the community property method, is one-half (1/2) his share of the couple's community income, plus his own separate income. The deductions in Table 723.03 are subtracted from his income. (7-1-99)

03. Income of Participant in Facility. A participant residing in the long-term care facility at least one (1) full calendar month, beginning with his most recent admission, must have the deductions in Subsection 723.03 subtracted from his income, after the AABD exclusions are subtracted from the income. Total monthly income includes income paid into an income (Miller) trust that month. The income deductions must be subtracted in the order listed. Remaining income is patient liability. (3-15-02)

- a. AABD Income Exclusions.** Subtract income excluded in determining eligibility for AABD cash. (7-1-99)
- b. Aid and Attendance and UME Allowances.** Subtract a VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse, unless the veteran lives in a state operated veterans' home. (3-30-01)
- c. SSI Payment Two (2) Months.** Subtract the SSI payment for a participant entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long-term care facility. (7-1-99)
- d. AABD Payment.** Subtract the AABD payment, and income used to compute the AABD payment, for a participant paid continued AABD payments up to three (3) months in long-term care. (7-1-99)
- e. First Ninety (\$90) Dollars of VA Pension.** Subtract the first ninety (\$90) dollars of a VA pension for a veteran in a private long-term care facility or a State Veterans Nursing Home. (5-3-03)
- f. Personal Needs.** Subtract forty dollars (\$40) for the participant's personal needs. For a veteran or surviving spouse in a private long-term care facility or a State Veterans Nursing Home the first ninety (\$90) dollars of VA pension substitutes for the forty dollar (\$40) personal needs deduction. (5-3-03)
- g. Employed and Sheltered Workshop Activity Personal Needs.** For an employed participant or participant engaged in sheltered workshop or work activity center activities, subtract the lower of the personal needs deduction of two hundred dollars (\$200) or his gross earned income. The participant's total personal needs allowance must not exceed two hundred and thirty dollars (\$230). For a veteran or surviving spouse with sheltered workshop or earned income, and a protected VA pension, the total must not exceed two hundred dollars (\$200). This is a deduction only. No actual payment can be made to provide for personal needs. (3-30-01)
- h. Home Maintenance.** Subtract two hundred and twelve dollars (\$212) for home maintenance cost if the participant had an independent living situation, before his admission for long-term care. His physician must certify in writing the participant is likely to return home within six (6) months, after the month of admission to a long-term care facility. This is a deduction only. No actual payment can be made to maintain the participant's home. (7-1-99)
- i. Maintenance Need.** Subtract a maintenance need deduction for a family member, living in the long-term care participant's home. A family member is claimed, or could be claimed, as a dependent on the Federal Income Tax return of the long-term care participant. The family member must be a minor or dependent child,

dependent parent, or dependent sibling of the long-term care participant. The maintenance need deduction is the AFDC payment standard for the dependents, computed according to the AFDC State Plan in effect before July 16, 1996. (7-1-99)

j. Medicare and Health Insurance Premiums. Subtract expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Medicare Part B premiums must not be subtracted, if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed. (7-1-99)

k. Mandatory Income Taxes. Subtract taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income. (7-1-99)

l. Guardian Fees. Subtract court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars (\$25). Where the guardian and trustee is the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars (\$25) monthly. (3-20-14)

m. Trust Fees. Subtract up to twenty-five dollars (\$25) monthly paid to the trustee for administering the participant's trust. (7-1-99)

n. Impairment Related Work Expenses. Subtract impairment-related work expenses for an employed participant who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services that are purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged. (3-20-14)

o. Income Garnished for Child Support. Subtract income garnisheed for child support to the extent the expense is not already accounted for in computing the maintenance need standard. (3-30-01)

p. Incurred Medical Expenses. Subtract amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount. (4-11-15)

q. Pre-existing Medical Expenses. Subtract amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. The deduction for medical and remedial care expenses is limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero. ()

(BREAK IN CONTINUITY OF SECTIONS)

725. PATIENT LIABILITY FOR PARTICIPANT WITH COMMUNITY SPOUSE.
After income ownership is decided, patient liability is determined using steps in Table 725.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step	Procedure	
01. AABD Income Exclusions	Subtract income excluded in determining eligibility for AABD cash.	

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		Procedure
02.	Aid and Attendance and UME Allowances	Subtract a VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse, unless the veteran lives in a state operated veterans' home.
03.	SSI Payment Two (2) Months	Subtract the SSI payment for a participant entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long-term care facility.
04.	AABD Cash	Subtract the AABD cash payment and income used to compute AABD cash, for a participant eligible to have his AABD cash continued up to three (3) months, while he is in long-term care.
05.	VA Pension	Subtract the first ninety (90\$) of the VA pension for a veteran.
06.	Personal Needs	Subtract forty dollars (\$40) for the participant's personal needs. Do not allow this deduction for a veteran.
07.	Employed and Sheltered Workshop Activity Needs	For an employed participant or participant engaged in sheltered workshop or work activity center activities subtract the lower of two hundred dollars (\$200) or his earned income.
08.	Community Spouse Allowance: Step a.	Compute the Community Spouse Allowance (CSA) using Step a. through Step c.
		Compute the Shelter Adjustment. Add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs.
		Shelter costs include rent, mortgage principal and interest, homeowner's taxes, insurance, and condominium or cooperative maintenance charges. The Standard Utility Allowance must be reduced by the value of any utilities included in maintenance charges for a condominium or cooperative. Subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is thirty percent (30%) of one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the Federal Office of Management and Budget (OMB) for a family of two (2) persons. The Shelter Adjustment is the positive balance remaining.
09.	Community Spouse Allowance: Step b.	Compute the Community Spouse Need Standard (CSNS). Add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the OMB for a family unit of two (2) members. The minimum CSNS is revised annually in July. The total CSNS may not exceed the maximum CSNS. The maximum CSNS is computed by multiplying one thousand five hundred dollars (\$1,500) by the percentage increase in the consumer price index for all urban Consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY	
Step	Procedure
10. Community Spouse Allowance: Step c.	<p>Compute the Community Spouse Allowance. Subtract the community spouse's gross income from the CSNS. The community spouse's income includes income produced by his resources. Round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. The CSA is subtracted as actually paid to the community spouse, up to the computed maximum.</p> <p>A larger spouse support amount must be used as the CSA, if court-ordered. The CSA ordered by a court is not subject to the CSA limit.</p>
11. Family Member Allowance (FMA)	<p>Compute the family member's gross income. Subtract the family member's gross income from the minimum CSNS. Divide the difference by three (3). Round cents to the next higher dollar.</p> <p>Any remainder is the FMA for that family member. The FMA is allowed, whether or not it is actually paid by the participant.</p> <p>A family member is, or could be claimed, as a dependent on the Federal income tax return of either spouse. The family member must be a minor or dependent child, dependent parent or dependent sibling of either spouse. The family member must live in the community spouse's home.</p>
12. Medicare and Health Insurance Premiums	<p>Subtract expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Do not subtract the Medicare Part B premiums if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed.</p>
13. Mandatory Income Taxes	<p>Subtract taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income.</p>
14. Guardian Fees	<p>Subtract court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars (\$25). Where the guardian and trustee are the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars (\$25) monthly.</p>
15. Trust Fees	<p>Subtract up to twenty-five dollars (\$25) monthly paid to the trustee for administering the participant's trust.</p>
16. Impairment Related Work Expenses	<p>Subtract impairment-related work expenses for an employed participant who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services, purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged.</p>

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		Procedure
17.	Income Garnisheed for Child Support	Subtract income garnisheed for child support to the extent the expense is not already accounted for in computing the Family Member Allowance.
18.	Incurred Medical Expenses	Subtract amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount.
<u>19.</u>	<u>Pre-existing Medical Expenses</u>	<u>Subtract amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. The deduction for medical and remedial care expenses is limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.</u>

~~(4-11-15)~~()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED,
BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-1502

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective after review by the legislature, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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

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

There are no changes to the pending rule aligning with federal eligibility requirements and the rule is being adopted as proposed. The complete text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 252 through 255](#).

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

There is no anticipated fiscal impact to the state general fund or any other funds as a result of this rulemaking.

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

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

These rule changes are needed to amend and align with the federal requirements for eligibility and the Department's current business practice for determining countable self-employment income. Subsections are being deleted from rule to remove authorized employment and the self-employment standard deduction.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

There is no anticipated fiscal impact to the state general fund or any other funds as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is to align with federal requirements and other Department rules.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Callie Harrold at (208) 334-0663.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-1502

105. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.

To be eligible for AABD cash and Medicaid, an individual must be a member of one (1) of the groups listed in Subsections 105.01 through 105.16 of this rule. An individual must also provide proof of identity as provided in Section 104 of these rules. (3-20-14)

01. U.S. Citizen. A U.S. Citizen or a "national of the United States." (3-20-14)

02. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (3-30-07)

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (3-30-07)

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (3-30-07)

c. The child is under eighteen (18) years of age; (3-30-07)

- d. The child is a lawful permanent resident; and (3-30-07)
- e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. (3-30-07)
- 03. Full-Time Active Duty U.S. Armed Forces Member.** A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. (3-30-07)
- 04. Veteran of the U.S. Armed Forces.** A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. (3-30-07)
- 05. Non-Citizen Entering the U.S. Before August 22, 1996.** A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) and remained continuously present in the U.S. until they became a qualified alien. (3-30-07)
- 06. Non-Citizen Entering on or After August 22, 1996.** A non-citizen who entered on or after August 22, 1996, and;
- a. Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from their date of entry; (3-30-07)
- b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; (3-30-07)
- c. Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; (3-30-07)
- d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; (4-7-11)
- e. Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; (4-7-11)
- f. Is an Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007; or (4-7-11)
- g. Is an Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. (4-7-11)
- 07. Qualified Non-Citizen Entering on or After August 22, 1996.** A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. (3-30-07)
- 08. American Indian Born in Canada.** An American Indian born in Canada under 8 U.S.C. 1359. (3-30-07)
- 09. American Indian Born Outside the U.S.** An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). (3-30-07)
- 10. Qualified Non-Citizen Child Receiving Federal Foster Care.** A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. (3-30-07)
- 11. Victim of Severe Form of Trafficking.** A victim of a severe form of trafficking in persons, as

defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (3-20-04)

- a. Is under the age of eighteen (18) years; or (3-20-04)
- b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (3-20-04)
- i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (3-20-04)
- ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (3-30-07)

12. Qualified Non-Citizen Receiving Supplement Security Income (SSI). A qualified non-citizen under 8 U.S.C. 1641(b) or (c), and is receiving SSI; or (3-20-04)

13. Permanent Resident Receiving AABD Cash On August 22, 1996. A permanent resident receiving AABD cash on August 22, 1996. (3-20-04)

~~**14. Employment Authorized Alien.** An alien granted an employment authorization document (EAD), as defined in 8 CFR Part 274a.12(e). (3-20-14)~~

~~**15. Individuals Not Meeting the Citizenship or Qualified Non-Citizen Requirements.** An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 105.01 through 105.14 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. (3-20-14)~~

(BREAK IN CONTINUITY OF SECTIONS)

402. SELF-EMPLOYMENT ALLOWABLE EXPENSES.

Allowable operating expenses subtracted from self-employment income are listed in Subsections 402.01 through 402.17 of this rule. (3-29-12)

~~**01. Self-Employment Standard Deduction.** The Department uses a standard self-employment deduction, unless the applicant claims that his actual allowable expenses exceed the standard deduction and provides proof of the allowable expenses described in Subsection 402.02 through 402.17 of this rule. The self-employment standard deduction is determined by subtracting fifty percent (50%) of the gross monthly self-employment income as calculated in Section 401 of these rules. (3-29-12)~~

- ~~**02. Labor.** Labor paid to individuals not in the family. (7-1-99)~~
- ~~**03. Materials.** Materials such as stock, seed and fertilizer. (7-1-99)~~
- ~~**04. Rent.** Rent on business property. (7-1-99)~~
- ~~**05. Interest.** Interest paid to purchase income producing property. (7-1-99)~~
- ~~**06. Insurance.** Insurance paid for business property. (7-1-99)~~
- ~~**07. Taxes.** Taxes on income producing property. (7-1-99)~~
- ~~**08. Business Transportation.** Business transportation as defined by the IRS. (7-1-99)~~
- ~~**09. Maintenance.** Landscape and grounds maintenance. (7-1-99)~~

- | | | |
|--------------------------|--|----------|
| 40 <u>9</u> . | Lodging. Lodging for business related travel. | (7-1-99) |
| 14 <u>0</u> . | Meals. Meals for business related travel. | (7-1-99) |
| 12 <u>1</u> . | Use of Home. Costs of partial use of home for business. | (7-1-99) |
| 13 <u>2</u> . | Legal. Business related legal fees. | (7-1-99) |
| 14 <u>3</u> . | Shipping. Business related shipping costs. | (7-1-99) |
| 15 <u>4</u> . | Uniforms. Business related uniforms. | (7-1-99) |
| 16 <u>5</u> . | Utilities. Utilities for business property. | (7-1-99) |
| 17 <u>6</u> . | Advertising. Business related advertising. | (7-1-99) |

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

These rule changes clarify gaps that have been identified in these rules and adjust to changes in current Medicaid practice regarding school-based services and therapy services. Further, these rule changes adjust requirements currently resulting in unnecessary regulatory burdens on providers in their efforts to remain in compliance with the rules.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 256 through 274](#).

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

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, Frede' Trenkle-MacAllister at (208) 287-1169.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Friday, October 23, 2015 9:00 a.m. MDT	Friday, October 23, 2015 12:00 p.m. MDT	Friday, October 23, 2015 2:00 p.m. PDT
Medicaid Central Office 3232 W. Elder Street Conference Room D -- West/East Boise, ID	Medicaid Region VI Office 1070 Hiline Road Suite #230 Pocatello, ID	Medicaid Region I Office 1120 Ironwood Drive Large Conference Room Coeur d'Alene, ID

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

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

These rule changes clarify gaps that have been identified in these rules and adjust to changes in current Medicaid practice regarding school-based services and therapy services. Further, these rule changes adjust requirements currently resulting in unnecessary regulatory burdens on providers in their efforts to remain in compliance with the rules.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

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 June 3, 2015, Idaho Administrative Bulletin, [Vol. 15-6, pages 42 and 43](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Frede' Trenkle-MacAllister at (208) 287-1169.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

LSO Rules Analysis Memo

Italicized red text that is double underscored is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1501

730. THERAPY SERVICES: DEFINITIONS.

For the purposes of these rules, the following terms are used as defined below: (4-2-08)

01. Duplicate Services. Services are considered duplicate: (4-2-08)

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 (4-2-08)

b. When more than one (1) type of therapy is provided at the same time. (4-2-08)

02. Feeding Therapy. Feeding Therapy means those therapy services necessary for the treatment of feeding disorders. Feeding disorders include problems gathering food and getting ready to suck, chew, or swallow it. ()

023. Maintenance Program. A ~~maintenance~~ program ~~established by a therapist that requires the skills of a therapist or therapy professional and~~ consists of ~~any combination of drills, techniques, exercises, treatments, or activities that preserve the participant's present level of functioning and prevent regression of that function. A maintenance program begins when:~~ ~~activities and mechanisms to assist a participant in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.~~ (4-2-08)()

~~a. The therapeutic goals of a treatment plan have been achieved and no further functional progress is expected to occur;~~ (4-2-08)

~~b. The client or his caregivers, or both, have been taught and can carry out the therapy procedures; or~~ (4-2-08)

~~c. The skills of a therapist are no longer required.~~ (4-2-08)

034. Occupational Therapy Services. Therapy services that: (4-2-08)

a. Are provided within the scope of practice of licensed occupational therapists ~~sy~~ professionals; (4-2-08)()

b. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and (4-2-08)

c. Improve the individual's ability to perform those tasks required for independent functioning. (4-2-08)

045. Physical Therapy Services. Therapy services that: (4-2-08)

a. Are provided within the scope of practice of licensed physical therapists ~~sy~~ professionals;

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

b. Are necessary for the evaluation and treatment of physical impairment or injury by the use of therapeutic exercise and the application of modalities that are intended to restore optimal function or normal development; and (4-2-08)

c. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. (4-2-08)

~~056.~~ **Speech-Language Pathology Services.** Therapy services that are: (4-2-08)

a. Provided within the scope of practice of licensed speech-language pathologists; and (4-2-08)

b. Necessary for the evaluation and treatment of speech and language disorders which result in communication disabilities; or (4-2-08)

c. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (4-2-08)

~~06. Supervision.~~ (4-2-08)

~~a. Direct supervision requires that the therapist be physically present and available to render direction in person and on the premises where the therapy is being provided. (4-2-08)~~

~~b. General supervision requires direct, on-premises contact between the therapist, the therapy assistant, and the participant at least every five (5) visits or once every week if seen on a daily basis. Between direct contacts, the therapist is required to maintain indirect, off-premises contact with the therapy assistant. These indirect, off-premises contacts may be by telephone, written reports, or group conferences. (4-2-08)~~

07. **Therapeutic Procedures.** Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. (4-2-08)

~~08. **Therapist.** An individual licensed by the appropriate Idaho state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. ()~~

~~089. **Therapist Therapy Professional.** An individual licensed by the appropriate Idaho state licensing board as an occupational therapist or occupational therapist assistant, physical therapist or physical therapist assistant, or speech-language pathologist. (4-2-08)()~~

~~09. **Therapy Assistant.** An individual licensed by the appropriate therapy licensure board to assist in the practice of occupational or physical therapy under the supervision of the appropriate licensed therapist. The therapy assistant is not recognized as an independent Medicaid provider. (4-2-08)~~

10. **Therapy Services.** Occupational therapy, physical therapy, and speech-language pathology services are all considered to be therapy services. These services are ordered by the participant's attending physician, nurse practitioner, or physician assistant as part of a plan of care. (4-2-08)

11. **Treatment Modalities.** A treatment modality is any physical agent applied to produce therapeutic changes to biological tissue, including the application of thermal, acoustic, light, mechanical or electrical energy. (4-2-08)

731. THERAPY SERVICES: PARTICIPANT ELIGIBILITY.

To be eligible for therapy services, a participant must be eligible for Medicaid benefits and must have: (4-2-08)

01. **Physician Order.** A physician order for therapy services; and ~~(4-2-08)~~()

~~02. **Referral.** A referral from their Healthy Connections Primary Care Provider when applicable;~~

~~(4-2-08)~~

032. A Therapy Evaluation Showing Need. A therapy evaluation of the participant showing a need for therapy due to a functional limitation, a loss or delay of skill, or both; and (4-2-08)

043. A Therapy Evaluation Establishing Participant Benefit. A therapy evaluation establishing that the participant will benefit and demonstrate progress as a result of the therapy services. (4-2-08)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.

Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, Idaho Infant Toddler Program, independent practitioners, and home health agencies. ~~(7-1-13)~~()

01. Service Description: Occupational Therapy and Physical Therapy. Modalities, therapeutic procedures, tests, and measurements as described in the Physical Medicine and Rehabilitation Subsection and the Neurology and Neuromuscular Procedures Subsection of the Physician's Current Procedural Terminology (CPT Manual) are covered with the following limitations: (4-2-08)

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. (4-2-08)

b. Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires the therapist to have direct, one-to-one, patient contact. (4-2-08)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or physician assistant. (4-2-08)

d. Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. (4-2-08)

e. Any modality that is defined as "unlisted" in the CPT Manual requires prior authorization by the Department. In this case, the therapist and the physician, nurse practitioner, or physician assistant must provide information in writing to the Department that documents the medical necessity of the modality requested. (4-2-08)

f. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, make clinical judgments or decisions, or take responsibility for the service. The therapist has full responsibility for the service provided. Therapy assistants act at the direction and under the supervision of the treating therapist and in accordance with state licensure rules. ~~(4-2-08)~~()

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology aides and assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. ~~(4-2-08)~~()

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (4-2-08)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not meet the criteria for a maintenance program. ~~(4-2-08)~~()

b. Services that address developmentally acceptable error patterns. (4-2-08)

c. Services that do not require the skills of a ~~therapist or~~ therapy ~~assistant~~ professional.

(4-2-08)()

~~d. Services provided by unlicensed aides or technicians, even if under the supervision of a therapist, except as provided under Section 854 of these rules.~~ (4-2-08)

~~ed.~~ Massage, work hardening, and conditioning. (4-2-08)

~~fe.~~ Services that are not medically necessary, as defined in Section 011 of these rules. (4-2-08)

~~g. Maintenance programs, as defined under Section 730 of these rules.~~ (4-2-08)

~~hf.~~ Duplicate services, as defined under Section 730 of these rules. (4-2-08)

~~ig.~~ Group therapy in settings other than school-based services and the Idaho Infant Toddler Program. (7-1-13)

h. Acupuncture (with or without electrical stimulation). ()

i. Biofeedback, unless provided to treat urinary incontinence. ()

j. Duplicate Services. ()

k. Services that are considered to be experimental or investigational. ()

l. Vocational Program. ()

m. Vision Therapy. ()

04. Service Limitations. (4-2-08)

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. (3-29-12)

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may authorize additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided to the Department. (3-29-12)

c. Exceptions to service limitations. (3-29-12)

i. Therapy provided by home health agencies is subject to the limitations on home health services contained in Section 722 of these rules. (3-29-12)

ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. (7-1-13)

iii. Therapy provided to EPSDT participants under the age of twenty-one (21) in accordance with the EPSDT requirements contained in Sections 881 through 883 of these rules, and in Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. (3-29-12)

d. Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. ()

e. Maintenance therapy is covered when an individualized assessment of the participant's condition

demonstrates that skilled care is required to carry out a safe and effective maintenance program. ()

f. Telehealth modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on telehealth in the provider handbook to promote quality services and program integrity. ()

733. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.

The Department will pay for therapy services rendered by ~~or under the supervision of a licensed therapist~~ a therapy professional if such services are ordered by ~~the attending~~ a physician, nurse practitioner, or physician assistant as part of a plan of care. (4-2-08)()

01. Physician Orders. (4-2-08)

a. All therapy must be ordered by a physician, nurse practitioner, or physician assistant. Such orders must include at a minimum, the service to be provided, the frequency, and, where applicable, the expected duration of ~~each therapeutic session~~ time for which the therapy will be needed. If the initial order is to evaluate and treat, but does not specify at least the type of service ordered and the frequency, then: (4-2-08)()

i. The therapist may perform a therapy evaluation based on the initial physician order for the evaluation; and ()

ii. The therapist must then develop a therapy plan of care based on that evaluation and send the plan to the ordering physician, nurse practitioner, or physician assistant and begin care; and ()

iii. The physician, nurse practitioner, or physician assistant must either sign an order specifying the service to be provided, the frequency and the duration, or they must sign the therapy plan of care that includes that information within thirty (30) days for therapy to continue. No claims may be billed until the complete order or the plan of care is signed by the physician, nurse practitioner, or physician assistant. ()

b. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions: (5-8-09)

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. (4-2-08)

ii. Therapy for individuals with chronic long-term medical conditions, as documented by physician, nurse practitioner, or physician assistant, must be reordered at least every ~~six (6) months~~ three hundred sixty-five (365) days. (4-2-08)()

02. Level of Supervision. (4-2-08)

~~a. General~~ Supervision of physical therapist assistants and occupational therapy assistants is required when therapy services are provided by outpatient hospitals, nursing facilities, home health agencies, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, the Idaho Infant Toddler Program, and providers of school-based services by the physical therapist or occupational therapist must be done according to the rules of the applicable licensure board. (7-1-13)()

~~b. Direct supervision of therapy assistants is required when therapy services are provided by independent practitioners.~~ (4-2-08)

03. Plan of Care. All therapy is provided under a plan of care that is established prior to beginning treatment. The plan of care must be signed by the person who established the plan. The plan of care must be consistent with the therapy evaluation and must contain, at a minimum: ()

a. Diagnoses: ()

- b.** Treatment goals that are measurable and pertain to the identified functional impairment(s); and ()
- c.** Type, frequency, and duration of therapy services. ()

734. THERAPY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

The following providers are qualified to provide therapy services as Medicaid providers. (4-2-08)

01. Occupational Therapist, Licensed. A person licensed by the State Board of Medicine to conduct occupational therapy assessment and therapy in accordance with the Occupational Therapy Practice Act, Title 54, Chapter 37, Idaho Code, and IDAPA ~~22.01.09~~ 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." ~~(4-2-08)~~()

02. Physical Therapist, Licensed. A person licensed by the Physical Therapy Licensure Board to conduct physical therapy assessments and therapy in accordance with the Physical Therapy Practice Act, Title 54, Chapter 22, Idaho Code, and IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board." (4-2-08)

03. Speech-Language Pathologist, Licensed. A person licensed by the Speech and Hearing Services Licensure Board to conduct speech-language assessments and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, and IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language, and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL) for Personal Care Services. The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. ~~(3-30-07)~~()

02. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or an educational facilities setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students, and which are included in the individual educational plan (IEP) for the participant student. ~~(3-29-10)~~()

03. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (7-1-13)

04. The Psychiatric Rehabilitation Association (PRA). An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. ~~<https://netforum.avecira.com/eWeb/StartPage.aspx?Site=USPRA>~~ <http://www.uspra.org> ~~(3-20-14)~~()

05. Practitioner of the Healing Arts. A physician's assistant, nurse practitioner, or clinical nurse specialist who is licensed and approved by the state of Idaho to make such recommendations or referrals for Medicaid services. (7-1-13)

06. Serious Mental Illness (SMI). In accordance with 42 CFR 483.102(b)(1), a person with SMI: (3-20-14)

- a.** Currently or at any time during the year, must have had a diagnosable mental, behavioral, or

emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-V; and (3-20-14)

b. Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. (3-20-14)

07. 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-V 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. (3-20-14)

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.

To be eligible for medical assistance reimbursement for covered services, school districts and charter schools must ensure the student is: (7-1-13)

01. Medicaid Eligible. Eligible for Medicaid and the service for which the school district or charter school is seeking reimbursement; (7-1-13)

02. School Enrollment. Enrolled in an Idaho school district or charter school; (7-1-13)

03. Age. Twenty-one (21) years of age or younger and the semester in which his twenty-first birthday falls is not finished; (3-30-07)

04. Educational Disability. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness." (7-1-13)

~~**05. Inpatients in Hospitals or Nursing Homes.** Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. Health-related services for students residing in an ICF/ID are eligible for reimbursement. (7-1-13)~~

~~**05. Parental Consent.** Providers must obtain a one-time parental consent to access public benefits or insurance from a parent or legal guardian for school-based Medicaid reimbursement. ()~~

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.

~~Psychosocial Rehabilitation (PSR);~~ Community Based Rehabilitation Services (CBRS). Behavioral Intervention, Behavioral Consultation, and Personal Care Services (PCS) have additional eligibility requirements. ~~(3-20-14)~~ ()

01. ~~Psychosocial Rehabilitation (PSR)~~ Community Based Rehabilitation Services (CBRS). To be eligible for ~~PSR~~ CBRS, the student participant must meet one (1) of the following: ~~(3-20-14)~~ ()

a. A student who is a child under eighteen (18) years of age must meet the Serious Emotional Disturbance (SED) eligibility criteria for children in accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code, ~~and have documented evidence of a history and physical examination that has been completed within the last twelve (12) months prior to the initiation of mental health services.~~ A child who meets the criteria for SED must experience a substantial impairment in functioning. The child's level and type of functional impairment must be documented in the ~~medical~~ school record. ~~The Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument~~ A Department-approved assessment must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at ~~regular intervals~~ least annually in order to determine the child's change in functioning that occurs as a result of mental health treatment. ~~Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that~~

~~the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following: Self harmful Behavior, Moods/Emotions, or Thinking. In addition, the child must have obtained a comprehensive diagnostic assessment that indicates:~~ (3-20-14)()

~~i. The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the child;~~ (3-20-14)

~~ii. The service can reasonably be expected to improve the child's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced; and~~ (3-20-14)

~~iii. Verification that the child is not at immediate risk of self harm or harm to others who cannot be stabilized, not in need of more restrictive care or inpatient care, and not over the age of eighteen (18).~~ (3-20-14)

b. A student who is eighteen (18) years old or older must meet the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria for SMI, as described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. ~~The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services.~~ The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: (3-20-14)()

i. Vocational/educational; (3-20-14)

ii. Financial; (3-20-14)

iii. Social relationships/support; (3-20-14)

iv. Family; (3-20-14)

v. Basic living skills; (3-20-14)

vi. Housing; (3-20-14)

vii. Community/legal; or (3-20-14)

viii. Health/medical. (3-20-14)

~~e. A student must meet the Department of Education's criteria for emotional disturbance found in the Idaho Special Education Manual available online at the Idaho Department of Education website, http://www.sde.idaho.gov/site/special_edu/.~~ (3-20-14)

02. Behavioral Intervention and Behavioral Consultation. To be eligible for behavioral intervention and behavioral consultation services, the student must: (3-20-14)

a. Meet the criteria for developmental disabilities as identified in Section 66-402(5), Idaho Code, and have documentation to support eligibility using the standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 501-503; and (3-20-14)()

b. Exhibit maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury,

criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by ~~at least two (2)~~ a raters familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by ~~at least two (2)~~ a raters familiar with the student, on a standardized behavioral assessment approved by the Department; and ~~(3-20-14)~~ ()

- c. Have maladaptive behaviors that interfere with the student's ability to access an education. (3-20-14)

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. ~~(3-20-14)~~ ()

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.

The Department will pay school districts and charter schools for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (7-1-13)

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (3-30-07)

- a. Vocational Services. (3-30-07)
- b. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. (3-30-07)
- c. Recreational Services. (3-30-07)

d. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. ~~()~~

02. Evaluation And Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-30-07)

- a. Be recommended or referred by a physician or other practitioner of the healing arts. A school district or charter school may not seek reimbursement for services provided prior to receiving a signed and dated recommendation or referral; (7-1-13)
- b. Be conducted by qualified professionals for the respective discipline as defined in Section 855 of these rules; (3-20-14)
- c. Be directed toward a diagnosis; ~~and~~ ~~(7-1-13)~~ ()
- d. Include recommended interventions to address each need-; and ~~(7-1-13)~~ ()
- e. Include name, title, and signature of the person conducting the evaluation.** ~~()~~

03. Reimbursable Services. School districts and charter schools can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts for the Medicaid services for which the school district or charter school is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided prior to receiving a signed and dated recommendation or referral. The recommendations or referrals are valid up to three hundred sixty-five (365) days. ~~(7-1-13)~~ ()

a. Behavioral Intervention. Behavioral Intervention is used to promote the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. It includes the development of replacement behaviors by conducting a functional behavior assessment and behavior implementation plan with the purpose ~~to~~ of preventing or treating behavioral conditions ~~of~~ for students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. The following staff-to-participant ratios apply:
(7-1-13)()

i. ~~There must be at least~~ Group services must be provided by one (1) qualified staff providing direct services for ~~every~~ a maximum of three (3) students, ~~unless the student has an assessment score of at least two (2) standard deviations from the mean in one (1) composite score.~~
(7-1-13)()

ii. ~~When intervention is provided by a professional for students with an assessment score of at least two (2) standard deviations from the mean in one (1) composite score, there must be at least one (1) qualified staff for every two (2) students.~~
(7-1-13)

iii. ~~When intervention is provided by a paraprofessional for students with an assessment score of at least two (2) standard deviations from the mean in one (1) composite score, group intervention is not allowable.~~
(7-1-13)

~~i.~~ As the number and severity of the students with behavioral issues increases, the staff-to-participant ~~student~~ ratio must be adjusted accordingly.
(7-1-13)()

~~iii.~~ Group services should only be delivered when the child's goals relate to benefiting from group interaction.
(7-1-13)

b. Behavioral Consultation. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members.
(7-1-13)

i. Behavioral consultation cannot be provided as a direct intervention service. (7-1-13)

ii. Behavioral consultation must be limited to thirty-six (36) hours per student per year. (7-1-13)

c. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician, and prior authorized, ~~based on medical necessity, in order to be billed~~. Authorized items must be for ~~used~~ at the school ~~at the location~~ where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be used for the student's exclusive use and must be ~~transferred~~ with the student if the student changes schools. ~~Equipment no longer usable by the student, may be donated to the school by the student~~ All equipment purchased by Medicaid belongs to the student.
(7-1-13)()

d. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his or her practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed.
(3-30-07)()

e. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. (3-30-07)

f. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements. Personal care services do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services:
(7-1-13)()

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care;
(7-1-13)

- ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with ~~bedpan~~ bathroom routines; (7-1-13)()
- iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (7-1-13)
- ~~iv. The continuation of developmental disabilities programs to address the activities of daily living needs in the school setting as identified on the child's PCS assessment, in order to increase or maintain independence for the student with developmental disabilities as determined by the nurse or qualified intellectual disabilities professional (QIDP); (7-1-13)~~
- ~~iv.~~ Assisting the student with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; (7-1-13)
- ~~vi.~~ Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation, and the requirements are met in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 303.01. (7-1-13)
- g. Physical Therapy and Evaluation. (3-30-07)
- h. Psychological Evaluation. (3-30-07)
- i. Psychotherapy. (3-30-07)
- j. ~~Psychosocial Rehabilitation (PSR)~~ Community Based Rehabilitation Services (CBRS) Services and Evaluation. ~~Psychosocial rehabilitation (PSR)~~ Community Based Rehabilitation ~~s~~Services and evaluation services that are interventions to assist reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. Training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, ~~study skills~~, and coping skills are types of interventions that may be reimbursed. This service is to prevent placement of the student into a more restrictive educational situation. (3-20-14)()
- k. Speech/Audiological Therapy and Evaluation. (3-30-07)
- l. Social History and Evaluation. (3-30-07)
- m. Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home; and school; ~~or location of services~~ when: (7-1-13)()
 - i. The student requires special transportation assistance, such as a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ~~ordered~~ recommended by a physician or other practitioner of the healing arts; (3-30-07)()
 - ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-30-07)
 - iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (3-30-07)
 - iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-30-07)
 - v. The mileage, as well as the services performed by the attendant, are documented. See Section 855 of these rules for documentation requirements. (3-20-14)
- n. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately

speaking or understanding English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (7-1-13)

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; documentation for interpretive service must include the Medicaid reimbursable health-related service being provided while the interpretive service is provided. ~~(3-30-07)~~ ()

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-30-07)

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-30-07)

854. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.

The following documentation must be maintained by the provider and retained for a period of ~~six~~ five ~~(65)~~ (7-1-13) years: ()

01. Individualized Education Program (IEP) and Other Service Plans. School districts and charter schools may bill for Medicaid services covered by a current Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP) ~~when the child turns three (3) years old~~, or Services Plan (SP) defined in the Idaho Special Education Manual on the State Department of Education website for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically-necessary health-related service, and lists all the Medicaid reimbursable services for which the school district or charter school is requesting reimbursement. The IEP and transitional IFSP must include: (7-1-13) ()

~~a.~~ Type, frequency, and duration of the service(s) provided; (7-1-13)

~~b.~~ Title of the provider(s), including the direct care staff delivering services under the supervision of the professional; (7-1-13)

~~c.~~ Measurable goals, when goals are required for the service; and (7-1-13)

~~d.~~ Specific place of service, if provided in a location other than school. (7-1-13) ()

02. Evaluations and Assessments. Evaluations and assessments must support services billed to Medicaid, and must accurately reflect the student's current status. Evaluations and assessments must be completed at least every (3) years. (7-1-13)

03. Service Detail Reports. A service detail report that includes: (7-1-13)

a. Name of student; (7-1-13)

b. Name, ~~and~~ title, and signature of the person providing the service; (7-1-13) ()

c. Date, time, and duration of service; (7-1-13)

d. Place of service, if provided in a location other than school; (7-1-13)

e. Category of service and brief description of the specific areas addressed; and (7-1-13)

f. Student's response to the service when required for the service. (7-1-13)

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. (7-1-13)

- 05. Documentation of Qualifications of Providers.** (7-1-13)
- 06. Copies of Required Referrals and Recommendations.** Copies of required referrals and recommendations. (7-1-13)
- a.** School-based services must be recommended or referred by a physician or other practitioner of the healing arts for all Medicaid services for which the school district or charter school is receiving reimbursement. (7-1-13)
- b.** A recommendation or referral must be obtained prior to the provision of services for which the school district or charter school is seeking reimbursement. Therapy requirements for the physician's order are identified in Section 733 of these rules. (7-1-13)()
- c.** A recommendation or referral must be obtained for the service at least every three hundred sixty-five (365) days. ()
- 07. Parental Notification.** School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.08 of this rule. (3-20-14)
- 08. Requirements for Cooperation with and Notification of Parents and Agencies.** Each school district or charter school billing for Medicaid services must act in cooperation with students' parents or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. (7-1-13)()
- a.** Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must ensure document that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must document that they provided the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and (7-1-13)()
- b.** Notification to Primary Care Physician (PCP). School districts and charter schools must request the name of the student's primary care physician and request a written consent to release and obtain information between the PCP and the school from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician: (7-1-13)()
- i. Results of evaluations within sixty (60) days of completion;* (7-1-13)
- ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and* (7-1-13)
- iii. A copy of progress notes, if requested by the physician, within sixty (60) days of completion.* (7-1-13)
- c.** Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district or charter school must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (7-1-13)
- 855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.** Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (7-1-13)
- 01. Behavioral Intervention.** Behavioral intervention must be provided by or under the supervision of a professional. (7-1-13)

- a. A behavioral intervention professional must meet the following: (7-1-13)
- i. An individual with an Exceptional Child Certificate who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity,” Section 028; or (7-1-13)
 - ii. An individual with an Early Childhood/Early Childhood Special Education Blended Certificate who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity,” Section 019; or (7-1-13)
 - iii. A Special Education Consulting Teacher who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity,” Section 029; or (7-1-13)
 - iv. Habilitative intervention professional who meets the requirements defined in IDAPA 16.03.10 “Medicaid Enhanced Plan Benefits,” Section 685; or (7-1-13)
 - v. Individuals employed by a school as certified Intensive Behavioral Intervention (IBI) professionals prior to July 1, 2013, are qualified to provide behavioral intervention; and (7-1-13)
 - vi. Must be able to provide documentation of one (1) year’s supervised experience working with children with developmental disabilities. This can be achieved by previous work experience gained through paid employment, university practicum experience, or internship. It can also be achieved by increased on-the-job supervision experience gained during employment at a school district or charter school. (7-1-13)
- b. A paraprofessional under the direction of a qualified behavioral intervention professional, must meet the following: (7-1-13)
- i. Must be at least eighteen (18) years of age; (7-1-13)
 - ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned, ~~and meet the requirements under the “Standards for Paraprofessionals Supporting Students with Special Needs,” available online at the State Department of Education website;~~ and (7-1-13) ()
 - iii. Must meet the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title I, Part A, Section 1119. (7-1-13)
- c. A paraprofessional delivering behavioral intervention services must be under the supervision of a behavioral intervention professional or behavioral consultation provider. The professional must observe and review the direct services performed by the paraprofessional on a monthly basis, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the behavioral intervention service. (7-1-13)
- 02. Behavioral Consultation.** 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 (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following: (7-1-13)
- a. An individual with an Exceptional Child Certificate who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity,” Section 028. (7-1-13)
 - b. An individual with an Early Childhood/Early Childhood Special Education Blended Certificate who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity,” Section 019. (7-1-13)
 - c. A Special Education Consulting Teacher who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity” Section 029. (7-1-13)
 - d. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity,” Section 027, excluding a registered nurse or audiologist. (7-1-13)

- e. An occupational therapist who is qualified and registered to practice in Idaho. (7-1-13)
- f. Therapeutic consultation professional who meets the requirements defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 685. (7-1-13)
03. **Medical Equipment and Supplies.** See Subsection 853.03 of these rules. (3-20-14)
04. **Nursing Services.** Nursing services must be provided by a registered nurse or licensed professional nurse (RN), or by a licensed practical nurse (LPN) licensed to practice in Idaho. (7-1-13)
05. **Occupational Therapy and Evaluation.** ~~Occupation therapy and evaluation must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. For therapy-specific rules, refer to Sections 730 through 739 of these rules.~~ (7-1-13)()
06. **Personal Care Services.** Personal care services must be provided by or under the direction of a registered nurse licensed by the State of Idaho. (7-1-13)
- a. Providers of PCS must have at least one (1) of the following qualifications: (7-1-13)
- i. Registered Nurse or Licensed Professional Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a registered nurse or licensed professional nurse; (7-1-13)
- ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; ~~or~~ (7-1-13)()
- iii. Certified Nursing Assistant (CNA). A person currently certified by the State of Idaho; or ()
- ~~iv.~~ Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services and meets the paraprofessional requirements under the Elementary and Secondary Education Act of 1965, as amended, Title I, Part A, Section 1119. The assistant must be at least age eighteen (18) years of age. Medically-oriented services may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." The professional nurse may require a certified nursing assistant (CNA) if, in their professional judgment, the student's medical condition warrants a CNA. (7-1-13)()
- b. The registered nurse (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: (7-1-13)()
- i. Development of the written PCS plan of care; (7-1-13)
- ii. Review of the treatment given by the personal assistant through a review of the student's PCS ~~record~~ service detail reports as maintained by the provider; and (7-1-13)()
- iii. Reevaluation of the plan of care as necessary, but at least annually. (7-1-13)
- ~~e. In addition to the RN oversight, the Qualified Intellectual Disabilities Professional (QIDP) as defined in 42 CFR 483.430 provides oversight for students with developmental disabilities when identified as a need on the PCS assessment. Oversight must include:~~ (7-1-13)
- ~~i. Assistance in the development of the PCS plan of care for those aspects of developmental disabilities programs that address the student's activities of daily living needs provided in the school by the personal assistant;~~ (7-1-13)
- ~~ii. Review of the developmental disabilities programs given by the personal assistant through a review of the student's PCS record as maintained by the provider and through on-site observation of the student; and~~

- (7-1-13)
- iii. ~~Reevaluation of the PCS plan of care as necessary, but at least annually.~~ (7-1-13)
- dc. The RN, ~~QIDP, or a combination of both,~~ 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. (7-1-13)()
07. **Physical Therapy and Evaluation.** ~~Physical therapy and evaluation must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho.~~ For therapy-specific rules, refer to Sections 730 through 739 of these rules. (7-1-13)()
08. **Psychological Evaluation.** A psychological evaluation must be provided by a: (7-1-13)
- a. Licensed psychiatrist; (7-1-13)
- b. Licensed physician; (7-1-13)
- c. Licensed psychologist; (7-1-13)
- d. Psychologist extender registered with the Bureau of Occupational Licenses; or (7-1-13)
- e. Endorsed or ~~C~~certified school psychologist. (7-1-13)()
09. **Psychotherapy.** Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (7-1-13)
- a. Psychiatrist, M.D.; (7-1-13)
- b. Physician, M.D.; (7-1-13)
- c. Licensed psychologist; (7-1-13)
- d. Licensed clinical social worker; (7-1-13)
- e. Licensed clinical professional counselor; (7-1-13)
- f. Licensed marriage and family therapist; (7-1-13)
- g. Certified psychiatric nurse (R.N.), as described in Subsection 707.13 of these rules; (7-1-13)
- h. Licensed professional counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; (7-1-13)
- i. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; (7-1-13)
- j. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or (7-1-13)
- k. Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-13)
10. ~~Psychosocial Rehabilitation (PSR)~~ Community Based Rehabilitation Services (CBRS). ~~Psychosocial rehabilitation~~ CBRS providers must be ~~provided by a~~ one of the following: (7-1-13)()

- a. Licensed physician, licensed practitioner of the healing arts, ~~or licensed psychiatrist;~~ (7-1-13)()
- b. ~~Licensed master's level psychiatric~~ Advanced practice professional nurse; (7-1-13)()
- c. Licensed psychologist; (7-1-13)
- d. Licensed clinical professional counselor or professional counselor; (7-1-13)
- e. Licensed marriage and family therapist ~~or associate marriage and family therapist;~~ (7-1-13)()
- f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (7-1-13)
- g. Psychologist extender registered with the Bureau of Occupational Licenses; (7-1-13)
- h. Licensed professional or registered nurse (RN); (7-1-13)
- i. Licensed occupational therapist; (7-1-13)
- j. Endorsed or ~~C~~certified school psychologist; (3-20-14)()
- ~~k.~~ Certified school social worker; or (3-20-14)
- ~~k.~~ Psychosocial rehabilitation (PSR) Community Based Rehabilitation Services specialist. A PSR CBRS specialist is: (3-20-14)()
- i. An individual who has a Bachelor's degree and holds a current PRA credential; or (3-20-14)
- ii. An individual who has a Bachelor's degree or higher and was hired on or after November 1, 2010, to work as a PSR CBRS specialist to deliver Medicaid-reimbursable mental health services. This individual may continue to do so for a period not to exceed thirty (30) months from the initial date of hire. The individual must show documentation that they are working towards this certification. In order to continue as a PSR CBRS specialist beyond a total period of thirty (30) months from the date of hire, the worker must have completed a certificate program or earned a certification in psychiatric rehabilitation based upon the primary population with whom he works in accordance with the requirements set by the PRA. (3-20-14)()
- iii. Credential required for PSR CBRS specialists ~~working primarily with adults.~~ (3-20-14)()
- (1) Applicants who intend to work primarily with adults, age eighteen (18) or older, must become a Certified Psychiatric Rehabilitation Practitioner in accordance with the PRA requirements. (3-20-14)
- (a) Applicants must be under the supervision of a licensed behavioral health professional, a physician, nurse, or a endorsed/certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision to review treatment provided to student participants on an ongoing basis. The frequency of the 1:1 supervision must occur at least on a monthly basis. ()
- (b) CBRS supervision can be conducted using telehealth when it is equally effective as direct on-site supervision. ()
- (2) Applicants who work primarily with adults, but also intend to work with participants under the age of eighteen (18), must have training addressing children's developmental milestones, or have evidence of classroom hours in equivalent courses. The worker's supervisor must determine the scope and amount of training the worker needs in order to work competently with children assigned to the worker's caseload. (3-20-14)
- (a) Applicants must be under the supervision of a licensed behavioral health professional staff, a

physician, nurse, or a endorsed/certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision to review treatment provided to student participants on an ongoing basis. The frequency of the 1:1 supervision must occur at least on a monthly basis. ()

(b) CBRS supervision can be conducted using telehealth when it is equally effective as direct on-site supervision. ()

~~iv. Credential required for PSR specialists working primarily with children.~~ (3-20-14)

~~(+3)~~ Applicants who intend to work primarily with children under the age of eighteen (18) must obtain a certificate in children's psychiatric rehabilitation in accordance with the PRA requirements. (3-20-14)

~~(24)~~ Applicants who primarily work with children, but who also intend to work with participants eighteen (18) years of age or older, must have training or have evidence of classroom hours addressing adult issues in psychiatric rehabilitation. The worker's supervisor must determine the scope and amount of training the worker needs in order to competently work with adults assigned to the worker's caseload. (3-20-14)

~~iv. An individual who is qualified to apply for licensure to the Idaho Bureau of Occupational Licenses, in any of the professions listed above in Subsections 855.10.a. through 855.10.i., who has failed his licensing exam or has been otherwise denied licensure is not eligible to provide services under the designation of PSR Specialist unless this individual has obtained one (1) of the PRA credentials.~~ (3-20-14)

11. Speech/Audiological Therapy and Evaluation. ~~Speech/audiological therapy and evaluation must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. For therapy-specific rules, refer to Sections 730 through 739 of these rules.~~ ~~(7-1-13)~~ ()

12. Social History and Evaluation. Social history and evaluation must be provided by a registered nurse or licensed professional nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (7-1-13)

13. Transportation. 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. (7-1-13)

14. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. The portions of the treatment plan that can be delegated to the paraprofessional must be identified in the IEP or transitional IFSP. ~~(7-1-13)~~ ()

a. Occupational Therapy (OT). Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. ~~(7-1-13)~~ ()

b. Physical Therapy (PT). Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision and service requirements. ~~(7-1-13)~~ ()

c. Speech-Language Pathology (SLP). Refer to IDAPA 24.23.01, "Rule of the Speech and Hearing Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for qualifications, supervision and service requirements for speech-language pathology. The guidelines have been incorporated by reference in Section 004 of these rules. ~~(7-1-13)~~ ()

i. Supervision must be provided by an SLP professional as defined in Section 734 of this chapter of rules. ()

ii. The professional must observe and review the direct services performed by the paraprofessional on a monthly basis, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. ()

(BREAK IN CONTINUITY OF SECTIONS)

857. SCHOOL-BASED SERVICE: QUALITY ASSURANCE AND IMPROVEMENT.

The provider will grant the Department immediate access to all information required to review compliance with these rules. ~~(3-30-07)~~ ()

01. Quality Assurance. Quality Assurance consists of reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department will work with the school to answer questions and provide clear direction regarding the corrective action plan. ()

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. ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1502

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is February 1, 2016. The pending rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and is also adopting a temporary rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

The Department is implementing outcome-based health care policy initiatives based on legislative intent language passed by the 2015 Legislature. Current rules for primary care case management and for health homes have been revised to support the new health care policy initiatives.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. The changes to the pending rule provide clarification to services and provider reimbursement. The original text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 275-289](#).

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

The temporary rule is to implement legislative intent language passed by the 2015 Legislature for Healthcare Policy Initiatives and confers a benefit.

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule or temporary rule, contact Cindy Brock at (208) 364-1983.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Tuesday, October 13, 2015 9:00 a.m. & 1:00 p.m. (MDT)	Wednesday, October 14, 2015 1:00 p.m. (PDT)
Medicaid Central Office 3232 W. Elder Street Conference Room D -- West/East Boise, ID	Medicaid Region I Office 1120 Ironwood Drive Large Conference Room Coeur d'Alene, ID

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

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

The Department is moving towards outcome-based health care policy initiatives with the implementation of the legislative intent language passed by the 2015 Legislature. Current rules for primary care case management and for health homes are being revised to support the new health care policy initiatives.

The changes to these rules will provide for the services and provider reimbursement changes needed to support the new model of care for participants. Outdated language will be removed from these rules and other references needed to support the new model will be added.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

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 June 3, 2015, Idaho Administrative Bulletin, [Vol. 15-6, pages 44](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at (208) 364-1983.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 28th Day of August, 2015.

LSO Rules Analysis Memo

Italicized red text that is *double underscored* is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1502

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-20-14)

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-30-07)

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and (3-30-07)

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification. (3-20-14)

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-30-07)

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-20-14)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-30-07)

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-30-07)

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. (3-30-07)

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-20-14)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho

Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. ()

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid eligible individuals and providers as specified in section 563 of these rules. ()

09. Services Delivered Via Telehealth. Services delivered via telehealth as defined in Title 54, Chapter 57, Idaho Code, must be identified as such in accordance with billing requirements published in the Idaho Medicaid Provider Handbook. Telehealth services billed without being identified as such are not covered. Services delivered via telehealth may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. ()

(BREAK IN CONTINUITY OF SECTIONS)

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (3-30-07)

a. Each participant may consult a participating physician or provider of his choice for care and receive covered services by presenting his identification card to the provider, subject to restrictions imposed by participation in Healthy Connections or enrollment in a Prepaid Ambulatory Health Plan (PAHP). (3-20-14)

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System and transfer the required information onto the appropriate claim form. Where the Electronic Verification System (EVS) indicates that a participant is enrolled in Healthy Connections, the provider must obtain a comply with referral from the primary care provider. Claims for services provided to participant designated as participating in Healthy Connections by other than the primary care provider, without proper referral, will not be paid or follow-up communication requirements defined in Section 210 of these rules. (3-30-07)()

c. Upon providing the care and services to a participant, the provider or his agent must submit a properly completed claim to the Department. (3-30-07)

d. The Department is to process each claim received and make payment directly to the provider. (3-30-07)

e. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in Appendix D of the Idaho Medicaid Provider Handbook. (3-30-07)

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: (3-30-07)

a. The provider's actual charge for service; or (3-30-07)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the

Department and reimbursement will be based on the documentation; or (3-30-07)

c. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (3-30-07)

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. (3-30-07)

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services which are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325. (3-30-07)

05. Review of Records. (3-30-07)

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Bureau of Audits and Investigations have the right to review pertinent records of providers receiving Medicaid reimbursement for covered services. (3-30-07)

b. The review of participants' medical and financial records must be conducted for the purposes of determining: (3-30-07)

i. The necessity for the care; or (3-30-07)

ii. That treatment was rendered in accordance with accepted medical standards of practice; or (3-30-07)

iii. That charges were not in excess of the provider's usual and customary rates; or (3-30-07)

iv. That fraudulent or abusive treatment and billing practices are not taking place. (3-30-07)

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: (3-30-07)

i. Withholding payments to the provider until access to the requested information is granted; or (3-30-07)

ii. Suspending the provider's number. (3-30-07)

06. Lower of Cost or Charges. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge or at a nominal charge are reimbursed fair compensation which is the same as reasonable cost. (3-30-07)

07. Procedures for Medicare Cross-Over Claims. (3-30-07)

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. (3-30-07)

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider automatically based upon the Medicare Summary Notice (MSN) information on the computer tape which is received from the Medicare Part B Carrier on a weekly basis. (3-30-07)

c. If a provider does not accept a Medicare assignment, a MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment. (3-30-07)

d. For all other services, a MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (3-30-07)

08. Services Reimbursable After the Appeals Process. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.

Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 545. (3-29-12)

d. Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)

e. Optometrist services are described in Sections 553 through 556. (3-29-12)

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 579 of these rules. (5-8-09)

- a. Healthy Connections services are described in Sections 560 through 566. (4-4-13)
- ~~b. Health Home services are described in Sections 570 through 576. (4-4-13)~~
- 06. Prevention Services.** The range of prevention services covered is described in Sections 580 through 649 of these rules. (4-4-13)
 - a. Child Wellness Services are described in Sections 580 through 586. (3-30-07)
 - b. Adult Physical Services are described in Sections 590 through 596. (3-30-07)
 - c. Screening mammography services are described in Sections 600 through 606. (3-30-07)
 - d. Diagnostic Screening Clinic services are described in Sections 610 through 614. (4-4-13)
 - e. Additional Assessment and Evaluation services are described in Section 615. (4-4-13)
 - f. Health Questionnaire Assessment is described in Section 618. (4-4-13)
 - g. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)
 - h. Nutritional services are described in Sections 630 through 636. (3-30-07)
 - i. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)
- 07. Laboratory and Radiology Services.** Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)
- 08. Prescription Drugs.** Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)
- 09. Family Planning.** Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)
- 10. Outpatient Behavioral Health Services.** Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. (3-20-14)
- 11. Inpatient Psychiatric Hospital Services.** Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-20-14)
- 12. Home Health Services.** Home health services are described in Sections 720 through 729 of these rules. (5-8-09)
- 13. Therapy Services.** Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)
- 14. Audiology Services.** Audiology services are described in Sections 740 through 749 of these rules. (5-8-09)
- 15. Durable Medical Equipment and Supplies.** The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)
 - a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)
 - b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

- c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)
- 16. **Vision Services.** Vision services are described in Sections 780 through 789 of these rules. (5-8-09)
- 17. **Dental Services.** The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (3-29-12)
- 18. **Essential Providers.** The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)
 - a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)
 - b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)
 - c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)
 - d. School-Based services are described in Sections 850 through 857. (3-20-14)
- 19. **Transportation.** The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)
 - a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)
 - b. Non-emergency medical transportation services are described in Sections 870 through 876. (4-4-13)
- 20. **EPSDT Services.** EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)
- 21. **Specific Pregnancy-Related Services.** Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. **Review Prior to Delivery of Outpatient Services.** Failure to obtain a timely review from the Department or its quality improvement organization (QIO) prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, for participants who are eligible at the time of service, will result in a retrospective review. The Department will assess a late review penalty, as outlined in Subsection 405.05 of these rules, when a review is conducted due to an untimely request. (4-4-13)

02. **Follow-Up for Emergency Room Patients ~~with Chronic Conditions~~.** Hospitals must establish procedures to refer Medicaid participants ~~with targeted chronic diseases defined in Section 560 of these rules~~ who are not enrolled in Healthy Connections to an Idaho Medicaid Healthy Home Connections provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Healthy Home Connections provider with that PCP. (4-4-13)()

(BREAK IN CONTINUITY OF SECTIONS)

500. PHYSICIAN SERVICES: DEFINITIONS.

01. **Physician Services.** Physician services include the treatment of medical and surgical conditions by

doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 390 and Subsection 502.01 of these rules. Physician services as defined in Subsection 500.01 of this rule will be reimbursed by the Department. (5-8-09)

02. Psychiatric Telehealth. ~~Psychiatric Telehealth is an electronic real time synchronous audio visual contact between a physician and participant related to the treatment of the participant. The participant is in one (1) location, called the hub site, with specialized equipment including a video camera and monitor, and with the hosting provider. The physician is at another location, called the spoke site, with specialized equipment. The physician and participant interact as if they were having a face-to-face service. This rule does not apply to outpatient behavioral health services provided through the Idaho Behavioral Health Plan (IBHP) that are delivered via telehealth methods as defined in Title 54, Chapter 57, Idaho Code.~~ (3-20-14)()

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

01. Outpatient Psychiatric Mental Health Services. Physician services not provided through the IBHP as outpatient psychiatric mental health services are limited to twelve (12) hours of psychiatric evaluations per eligible participant in any twelve (12) month period; and any combination of individual or group psychotherapy services provided by a physician up to a maximum of forty-five (45) hours of service in the consecutive twelve (12) months period beginning with the first such service. (3-20-14)

02. Sterilization Procedures. Particular restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. (3-30-07)

03. Abortions. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-30-07)

04. Tonometry. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. (3-30-07)

05. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services which are described and supported by the diagnosis. (3-30-07)

06. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. (3-30-07)

07. Corneal Transplants and Kidney Transplants. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (3-30-07)

08. Psychiatric Telehealth. ~~Payment for psychiatric Synchronous interaction telehealth services not provided through the IBHP is limited to psychiatric services for diagnostic assessments, pharmacological management, and psychotherapy with evaluation and management services twenty (20) to thirty (30) minutes in duration. Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. Service will not be reimbursed when provided via a videophone or webcam.~~ encounters, delivered as defined in Title 54, Chapter 57, Idaho Code, are reimbursable as follows: (3-20-14)()

a. Physician services delivered via telehealth are subject to primary care provider communication requirements in Section 210 of these rules. The Department will define limitations for telehealth in the Idaho Medicaid Provider Handbook to promote quality services and program integrity. ()

b. Fee for service reimbursement is not available for a telephone conversation, electronic mail

message (e-mail), or facsimile transmission (fax) between a physician and a participant. ()

(BREAK IN CONTINUITY OF SECTIONS)

560. **HEALTHY CONNECTIONS ~~AND IDAHO MEDICAID HEALTH HOME~~: DEFINITIONS.**

Healthy Connections is a primary care case management program in which a primary care provider or team provides comprehensive medical care for participants with the goal of improving health outcomes. For purposes of this Sub Area that includes Sections 560 through 579~~66~~ of these rules, the following terms and definitions apply:

~~(4-4-13)~~()

~~01. **Best Practices Protocol.** A regimen of proven, effective and evidence-based practices. (4-2-08)~~

~~02. **Care Plan.** A patient specific document that identifies health care orders for the patient and serves as a guide to care. It can either be written for an individual patient or be retrieved from a computer and individualized. (4-4-13)~~

~~03. **Chronic Disease Management.** The process of applying best practices protocol to manage a chronic disease in order to produce the best health outcomes for a participant with the targeted chronic disease. (4-2-08)~~

01. **Capitated Payments.** Payments to a primary care provider made on a per assigned participant per month basis for patient services. Capitated payments will vary to reflect the level of responsibility for services the provider elects to provide as described in Section 564 of these rules. Capitated payments may include payment for all provider services at a set rate per participant per month when that type of full-risk reimbursement is agreed to by the provider and the Department. ()

~~042. **Clinic.** Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. (3-30-07)~~

~~05. **Covered Services.** Those medical services and supplies for which reimbursement is available under the State Plan. (3-30-07)~~

~~063. **Grievance.** The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. (3-30-07)~~

~~07. **Health Home.** A primary care provider organization contracted with Medicaid to lead a team approach for chronic disease management. The Health Home provides comprehensive patient centered care management and health promotion services to patients with chronic conditions in accordance with the requirements described in section 560 through 579 of these rules and Section 1945 of the Social Security Act. (4-4-13)~~

~~08. **Health Information Technology.** Electronic tools utilized to securely exchange or manage health information between two or more entities. (4-4-13)~~

~~09. **Healthy Connections.** The provision of health care services through a single point of entry for the purposes of managing participant care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as managed care. Healthy Connections is a primary care case management model. (4-2-08)~~

~~10. **Individual or Family Supports.** Community based social supports or recovery services available to assist individuals or families in need. (4-4-13)~~

~~11. **National Committee for Quality Assurance (NCQA).** Accrediting organization which develops health care performance measurements and provides certifications of quality to health care providers. (4-4-13)~~

04. **Patient-Centered Medical Home.** A model of primary care that is patient-centered.

comprehensive, team-based, coordinated, accessible, and focused on quality and safety. This results in primary care being delivered at the right place, at the right time, and in the manner that best suits a patient's needs. ()

~~1205.~~ **Preventive Care.** Medical care that focuses on disease prevention and health maintenance. (4-4-13)

~~1306.~~ **Primary Care Case Management.** ~~The process~~ A model of care in which ~~a~~ primary care providers ~~is and their primary care team are~~ responsible for direct care of a participant, and for coordinating ~~and controlling~~ access to ~~or initiating and/or supervising other health care~~ services ~~needed by the participant~~ that improve the health of the participant. (4-2-08)()

~~1407.~~ **Primary Care Provider (PCP).** A ~~qualified medical professional~~ physician, physician assistant, or advanced practice registered nurse as defined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," who contracts with Medicaid to coordinate and manage the care of ~~certain~~ participants enrolled in the Healthy Connections program. (4-4-13)()

08. Primary Care Team. A multidisciplinary team of health care providers who work together to meet the physical, emotional, and psychological needs of their patients using a patient-centered and coordinated approach. ()

~~15. Qualified Medical Professional. A duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered.~~ (3-30-07)

~~16. Quality Improvement Program. A program of organized, ongoing, and systematic efforts to improve and assess the quality of care within a primary care provider practice or organization.~~ (4-4-13)

~~17. Quality Measures. A measure of health care performance based on specified dimensions of care and service.~~ (4-4-13)

~~1809.~~ **Referral.** A documented communication from a participant's primary care provider (PCP) to another Medicaid provider authorizing specific covered services subject to primary care case management that are not provided by the participant's PCP. (4-4-13)

~~19. Risk Factor. A characteristic, condition, or behavior that increases the possibility of disease or injury.~~ (4-4-13)

~~20. Targeted Chronic Disease. A disease identified by the Department for management under the Idaho Medicaid Health Home program. Specific conditions are identified in the Medicaid Provider Handbook available at www.idmedicaid.com.~~ (4-4-13)

~~210.~~ **Transitional Care.** ~~The care or services provided by a health care provider~~ A set of actions designed to ensure the coordination and continuity of health care of the as patients as they move transfer between health different locations or different levels of care settings or between healthcare providers within the same location. (4-4-13)()

(BREAK IN CONTINUITY OF SECTIONS)

562. **HEALTHY CONNECTIONS:** ~~COVERAGE AND LIMITATIONS~~ **PRIMARY CARE SERVICES.**

01. Exempted Eligible Services. ~~All services are subject to primary care case management unless specifically exempted. The following services are exempt~~ Participants enrolled with a primary care provider (PCP) are eligible to receive: (3-30-07)()

- a. ~~Family planning services~~ Basic care management and care coordination; (3-30-07)()
- b. ~~Treatment for emergency medical conditions defined in Subsection 010.23 of these rules~~ Timely access to routine primary care; and (4-4-13)()
- c. ~~Hospital admissions subsequent to an emergency room visit provided that the patient's discharge is coordinated with a PCP~~ A patient-centered health care decision making process; (4-4-13)()
- d. ~~Dental care~~ Twenty-four (24) hour, seven (7) days per week access to an on-call medical professional; and (4-2-08)()
- e. ~~Podiatry (performed in the office);~~ Referral to other medically necessary services as specified in Section 210 of these rules, based on the clinical judgement of their primary care provider. (3-30-07)()
- ~~f. Audiology (hearing tests or screening, does not include ear/nose/throat services); (3-30-07)~~
- ~~g. Optical/Ophthalmology/Optomist services (performed in the office); (3-30-07)~~
- ~~h. Chiropractic (performed in the office); (3-30-07)~~
- ~~i. Pharmacy (prescription drugs only); (3-30-07)~~
- ~~j. Nursing home; (3-30-07)~~
- ~~k. ICF/ID services; (3-30-07)~~
- ~~l. Immunizations (not requiring an office visit); (4-2-08)~~
- ~~m. Flu shots and/or pneumococcal vaccine (not requiring an office visit); (3-30-07)~~
- ~~n. Diagnosis and/or treatment for sexually transmitted diseases; (3-30-07)~~
- ~~o. One screening mammography per calendar year for women age forty (40) or older; (3-30-07)~~
- ~~p. Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; (4-2-08)~~
- ~~q. In-home services, known as Personal Care Services and Personal Care Services Case Management; (4-2-08)~~
- ~~r. Laboratory services, including pathology; (4-2-08)~~
- ~~s. Anesthesiology services; (3-29-12)~~
- ~~t. Radiology services; (4-4-13)~~
- ~~u. Services rendered at an Urgent Care Clinic when the participant's PCP's office is closed; (4-4-13)~~
- ~~v. School based services; (4-4-13)~~
- ~~w. Services managed directly by the Department, as defined in the provider handbook for those services at www.idmedicaid.com; and (4-4-13)~~
- ~~x. Pregnancy related services provided by an obstetrician or gynecologist not enrolled as a Healthy Connections provider. (4-4-13)~~

02. ~~Change in Services That Require a Referral~~ Primary Care Provider. ~~The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and providers.~~ Participants may change their primary care provider at any time by contacting Healthy Connections staff.
(3-30-07)()

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. ~~Primary Care Case Management~~. ~~Under the Healthy Connections model of managed care, each participant obtains medical services through a PCP. This provider either provides the needed service, or makes a referral for needed services. This management function neither reduces nor expands the scope of covered services.~~ Changes to Requirements. The Department will provide sixty (60) day notice of any substantive and significant changes to requirements for referrals, primary care provider reimbursement, as specified in Section 565 of these rules, or provider duties on its website and provider portal. The Department will provide a method to allow providers to provide input and comment on proposed changes.
(4-2-08)()

~~a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the participant's care, providing primary care services, and making referrals for services when medically necessary. All services not specifically exempted in Section 562 of these rules require receipt of a referral prior to delivery of services. Services that require a referral, but are provided without a referral are not covered. All referrals must be documented in the participant's patient record.~~
(4-4-13)

~~b. Changing PCP. If a participant is dissatisfied with his PCP, he may change providers by contacting his designated Healthy Connections Representative at least ten (10) days prior to the end of the month. The change is effective the first day of the following month. This advance notice requirement may be waived by the Department.~~
(4-4-13)

~~c. Changing Service Areas. A participant who moves from the area where he is enrolled must contact his designated Healthy Connections Representative to disenroll from his current PCP and enroll with a new PCP in the area where moving. Enrollment with the new PCP is effective the first day of the month following the request.~~
(4-4-13)

02. Problem Resolution. (3-30-07)

a. To help assure the success of Healthy Connections, the Department provides a mechanism for timely and personal attention to problems and complaints related to the program. (4-4-13)

b. To facilitate problem resolution, the Department will have a designated representative who will receive and attempt to resolve all complaints and problems related to the program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. (4-4-13)

c. A participant or a provider may register a complaint or notify the Department of a problem related to Healthy Connections either in writing, electronically, or by telephone to the designated representative. The designated representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (4-4-13)

d. If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the designated representative, he may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. (4-4-13)

e. Decisions in response to grievances may be appealed. Appeals are governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed according to the provisions of that chapter. (4-4-13)

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

~~01. **Provider Participation Qualifications.** Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. **Primary Care Providers.** Primary care services may be provided by enrolled physicians, physician assistants, advanced practice registered nurses, and by care teams under those providers' direction. (3-30-07)()~~

~~02. **Provider Duties.** All Healthy Connections providers are responsible for delivering the services listed in Section 562 of these rules. ()~~

~~03. **Additional Services.** Healthy Connections providers may also elect to provide specific additional sets of patient-centered medical home services in exchange for increased reimbursement as described in Section 565 of these rules. The definition and provision of additional patient-centered medical home services are subject to specific requirements as defined by the Department and described in the Idaho Medicaid Provider Handbook and individual provider agreements with the Department. Additional services may include: ()~~

- ~~a. **Connection to the Idaho Health Data Exchange;** ()~~
- ~~b. **Maintaining third-party patient-centered medical home recognition or certification;** ()~~
- ~~c. **Expanded patient access to services;** ()~~
- ~~d. **Provision of an evidence-based primary care service model that enables improved patient health outcomes;** ()~~
- ~~e. **Reporting clinical data to the Department to allow for assessment of provider abilities and impact of their services on patient health outcomes;** ()~~
- ~~f. **Coordination of transitions of care between health care settings;** ()~~
- ~~g. **Integration of behavioral health services; and** ()~~
- ~~h. **Other indicators of improved patient health outcomes associated with primary care provider abilities.** ()~~

~~024. **Provider Participation Conditions and Restrictions.** (3-30-07)~~

- ~~a. **Quality of Services.** Each provider must: (4-4-13)~~
 - ~~i. **Maintain and provide services in accordance with community standards of care;** (4-4-13)~~
 - ~~ii. **Exercise his best efforts to effectively control utilization of services; and** (4-4-13)~~
 - ~~iii. **Provide twenty-four (24) hour coverage by telephone to assure participant access to services.** (4-4-13)~~
- ~~ba. **Provider Agreements.** Each independent provider or provider organization participating in primary care case management must: (4-4-13)~~
 - ~~i. **Sign an agreement;** (4-4-13)~~
 - ~~ii. **Enroll with the Department all primary care providers and all clinic locations participating in the Healthy Connections program; and** (4-4-13)~~
 - ~~iii. **Sign an addendum to the primary care case management provider agreement when participating in the Idaho Medicaid Health Home program. Complete pre-enrollment requirements for participation in the Healthy Connections program as defined by the Department in the Idaho Medicaid Provider Handbook. (4-4-13)()**~~

~~eb.~~ Patient Limits. A provider may limit the number of participants he manages. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. A provider may change the participant limit effective the first day of any month. The provider must make the request in writing to the Department thirty (30) days prior to the effective date of the change. ~~This advance notice requirement may be waived by the Department.~~ (4-4-13)()

~~ec.~~ Disenrollment. When the provider-patient relationship breaks down due to failure of the participant to follow the care plan or for other reasons, a provider may choose to withdraw as the participant's primary care provider effective the first day of any month. The PCP must notify in writing, both the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (4-4-13)

~~ed.~~ Record Retention. Each provider must: (4-4-13)

i. Retain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service; (4-4-13)

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP; and (4-4-13)

iii. Disclose information required by Subsection 205.01 of these rules, when applicable. (4-4-13)

~~fe.~~ Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. (3-30-07)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

~~01. Case Management Fee. Reimbursement is as follows:-~~ (4-2-08)

~~a. A PCP is paid a case management fee for primary care case management services based on the level of each participant's health care needs.~~ (4-4-13)

~~b. A PCP enrolled in the Idaho Medicaid Health Home program is paid a chronic disease case management fee.~~ (4-4-13)

~~c. The amount of the fee is determined by the Department.~~ (4-4-13)

~~d. The amount of the fee is fixed and the same for all participating PCPs.~~ (4-2-08)

01. Capitated Payments. Healthy Connections providers are compensated for their patient care services on a per participant per month basis. ()

~~02. Primary Care Case Management Reimbursement is based on:-~~ (3-29-12)

~~a. The number of participants enrolled with the provider on the first day of each month multiplied by the amount of the case management fee established for participants enrolled in the Basic Plan Benefit package;~~ (4-4-13)

~~b. The number of participants enrolled with the provider on the first day of each month, multiplied by the amount of the case management fee established for participants enrolled in the Enhanced Plan Benefit package; and~~ (4-4-13)

~~c. An incentive payment is added per participant to the primary care case management fee in Subsection 565.01.a. of this rule when the PCP offers extended hours of service in one (1) of the following ways:~~ (4-4-13)

~~i. The number of hours the PCP's office is available for delivery of service to participants equals or exceeds forty six (46) hours per week. The extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee; or (4-4-13)~~

~~ii. The PCP has electronic health records available and accessible for delivery of services at a nearby service location that is within the same Healthy Connections provider organization and makes services available to the participant at least forty six (46) hours per week. The alternate location and extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee. (4-4-13)~~

~~iii. The number of participants enrolled with an Idaho Medicaid Health Home provider on the first day of the month for services described in Section 572 these rules, multiplied by the case management fee established per participant enrolled in that program. (4-4-13)~~

02. Capitated Payment Amounts. Capitated payment amounts are determined by the Department and reflect the complexity of the patient's health combined with the provider's ability to impact patient health outcomes. This monthly payment to a provider is based on the number of participants assigned to the provider on the first day of each month. ()

03. Advanced Practice Registered Nurse Telehealth Services. Services provided via telehealth by advanced practice registered nurse enrolled as Healthy Connections providers will be reimbursed within the limitations defined by the Department for telehealth services in the Idaho Medicaid Provider Handbook. Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between an advanced practice registered nurse and a participant. ()

(BREAK IN CONTINUITY OF SECTIONS)

~~567.—569. (RESERVED)~~

SUB-AREA: PREVENTION SERVICES
(Sections 570—649)

570. IDAHO MEDICAID HEALTH HOME: DEFINITIONS.
For purposes of the Idaho Medicaid Health Home program, the terms and definitions in Section 560 of these rules apply. (4-4-13)

571. IDAHO MEDICAID HEALTH HOME: PARTICIPANT ELIGIBILITY.

01. Eligibility. ~~A Medicaid participant diagnosed with two (2) targeted chronic diseases, or one (1) targeted chronic disease and one (1) or more risk factors is eligible for enrollment in the Idaho Medicaid Health Home program. (4-4-13)~~

02. Eligibility Determination. ~~A participant who meets the diagnostic criteria for health home eligibility is identified by the PCP to the Department. The Department will utilize claims data and other documentation as needed to verify the participant is eligible for Idaho Medicaid Health Home services. (4-4-13)~~

572. IDAHO MEDICAID HEALTH HOME: COVERAGE AND LIMITATIONS.
The following services are covered for an eligible participant assigned to a Health Home provider: (4-4-13)

01. Comprehensive Care Management. ~~A Health Home provider must develop and implement a patient centered care plan based on an individual's health risk assessment. The care plan must describe how the Health Home provider will coordinate clinical care with other providers as well as non-clinical health care related needs and services. (4-4-13)~~

02. Care Coordination and Health Promotion. ~~A Health Home provider must: (4-4-13)~~

- ~~a. Coordinate the participant's care by sharing clinical information relevant to patient care with other providers; (4-4-13)~~
- ~~b. Provide educational information and information about health care resources to the participant; (4-4-13)~~
- ~~c. Have ongoing communication with the participant to encourage compliance with prescribed treatment; and (4-4-13)~~
- ~~d. Provide other activities necessary to facilitate improved health outcomes for the participant. (4-4-13)~~

~~03. Comprehensive Transitional Care. A Health Home provider must: (4-4-13)~~

- ~~a. Receive relevant medical information from and share relevant medical information with emergency rooms and inpatient facilities to foster a coordinated approach to preventing avoidable readmissions; and (4-4-13)~~
- ~~b. Review and update care plans after unplanned admissions to adjust care coordination and management activities to address identifiable causes for the admission. (4-4-13)~~

~~04. Individual, Family, Community, and Social Support Services. A Health Home provider must: (4-4-13)~~

- ~~a. Coordinate care in a manner that effectively utilizes available individual and family supports to improve and maintain the health of the participant; and (4-4-13)~~
- ~~b. Provide information on available community and social support services that aid in promoting healthy behaviors and reducing physical and mental health risk factors. (4-4-13)~~

~~573. IDAHO MEDICAID HEALTH HOME: PROCEDURAL REQUIREMENTS.~~

~~01. Provider Agreement. A Health Home provider must sign an addendum to the primary care case management provider agreement which identifies the location of the Health Home and other requirements necessary to meet the Health Home service requirements in these rules. (4-4-13)~~

~~02. Data Reporting. Health Home providers must report data to the Department on a periodic basis in keeping with schedules outlined in the provider handbook and the terms of the Health Homes provider agreement. (4-4-13)~~

~~03. Quality Improvement Program. A provider must establish a continuous quality improvement program directed towards improving care for patients with chronic conditions. (4-4-13)~~

~~574. IDAHO MEDICAID HEALTH HOME: PROVIDER QUALIFICATIONS AND DUTIES.~~

~~01. Provider Infrastructure and Health Home Assessment. A prospective Health Home provider must complete a Health Home practice assessment in cooperation with the Department to determine the ability of the provider to provide the required services in keeping with a patient centered medical home model. This assessment must demonstrate that the provider; (4-4-13)~~

- ~~a. Has identified the qualified medical and mental health professionals and other resources available to provide Health Home services; (4-4-13)~~
- ~~b. Has the ability to utilize health information technology to coordinate and facilitate communication of health information and to link to services; (4-4-13)~~
- ~~c. Is able to submit clinical and practice transformation data within six (6) months of the date the provider agreement is signed; and (4-4-13)~~

~~d. Has a chronic disease patient registry in place within three (3) months of the date the provider agreement is signed. (4-4-13)~~

~~02. Qualifications. An Idaho Medicaid Health Home provider must: (4-4-13)~~

~~a. Possess a current NCQA patient-centered medical home level one (1) recognition, or demonstrate that the provider is actively pursuing that recognition. A provider that does not achieve this NCQA recognition within two (2) years of the initiation date of their Idaho Medicaid Health Home provider agreement will be terminated as a Health Home provider for non-compliance with the provider agreement; (4-4-13)~~

~~b. Be enrolled as a Healthy Connections primary care provider (PCP); (4-4-13)~~

~~c. Sign an addendum to their primary care provider agreement which identifies the location of the enrolled site and indicates reporting schedule and quality measurement requirements; (4-4-13)~~

~~d. Have qualified medical professionals, licensed to practice in the state where services are being rendered; and (4-4-13)~~

~~e. Maintain office hours that allow enhanced access to care as described in Section 565.02 of these rules. (4-4-13)~~

~~03. Provider Duties. A Health Home provider must provide or coordinate the following elements of Health Home services: (4-4-13)~~

~~a. Care Plan. Develop a patient centered care plan for each participant that coordinates and integrates both clinical and non-clinical health care related needs and services; (4-4-13)~~

~~b. Chronic Disease Management. Provide access to chronic disease management, including self-management support to the participant and the participant's family; (4-4-13)~~

~~c. Individual, Family, and Community Supports. Facilitate access to individual, family, and community supports outlined in the provider's agreement. (4-4-13)~~

~~d. Mental Health & Substance Abuse Services. Facilitate access to mental health and substance abuse services. (4-4-13)~~

~~e. Preventive Care. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance abuse disorders. (4-4-13)~~

~~f. Quality Improvement Program. Establish a continuous quality improvement program and report on quality improvement measures outlined in the provider agreement and the provider handbook. (4-4-13)~~

~~g. Quality of Services. Maintain and provide quality services for each Home Health participant. (4-4-13)~~

~~h. Transitional Care. Coordinate and provide access to comprehensive care management and transitional care from and to inpatient settings and from a pediatric to an adult system of health care. (4-4-13)~~

~~575. (RESERVED)~~

~~576. IDAHO MEDICAID HEALTH HOME: QUALITY ASSURANCE.~~

~~The Department will establish performance measurements to evaluate the effectiveness of the Idaho Medicaid Health Home program through the collection and reporting of quality measures as specified in Section 1945 of the Social Security Act. (4-4-13)~~

~~576. -- 579. (RESERVED)~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1503

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective after review by the legislature, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, and 42 U.S.C. 1396a(a)(25)(E).

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

There are no changes to the pending rule regarding third party liability for early and periodic screening and diagnosis services billed to third party insurers and the rule is being adopted as proposed. The complete text of the proposed rule was published in the July 1, 2015, Idaho Administrative Bulletin, [Vol. 15-7, pages 55 through 57](#).

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

This rulemaking is meant to be cost neutral. There will be no fiscal impact to the state general funds or any other funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Cale Coyle at (208) 364-1817.

DATED this 30th day of October, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, and 42 U.S.C. 1396a(a)(25)(E).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 15, 2015.

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

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

This rule change adds clarification of exceptions regarding third party liability for early and periodic screening and diagnosis services that are billed to third-party insurers. These rules will align with federal statutes.

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

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

This rulemaking is meant to be cost neutral. There will be no fiscal impact to the state general funds or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not feasible because these rules are to align with federal statutes.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cale Coyle at (208) 364-1817.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 22, 2015.

DATED this 17th Day of June, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1503

215. THIRD PARTY LIABILITY.

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for medical care and services rendered to a participant. (3-30-07)

02. Third Party Liability as a Current Resource. The Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. (3-30-07)

03. Withholding Payment. The Department must not withhold payment on behalf of a participant because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the participant's medical expense. (3-30-07)

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party when the party's liability is established after reimbursement to the provider is made, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions *of EPSDT*

~~and EPSDT-related services provided in Subsection 215.05 of this rule.~~ (3-30-07)()

a. The Department will seek reimbursement from a participant when a participant's liability is established after reimbursement to the provider is made; and (3-30-07)

b. In any other situation in which the participant has received direct payment from any third party resource and has not forwarded the money to the Department for services or items received. (3-30-07)

05. **Billing Third Parties First.** Medicaid providers must bill all other sources of direct third party payment, with the following exceptions: ~~of absent parent (court ordered) without secondary resources, prenatal, EPSDT and EPSDT related services before submitting the claim to the Department. If the resource is an absent parent (court ordered) and there are no other viable resources available or if the claims are for prenatal, EPSDT, or EPSDT related services, the claims will be paid and the resources billed by the Department.~~ (3-30-07)()

a. When the resource is a court-ordered absent parent and there are no other viable resources available, the claims will be paid and the resources billed by the Department; ()

b. Prenatal or preventive pediatric care including early and periodic screening and diagnosis. Screening and diagnosis program services include; ()

i. Regularly scheduled examinations and evaluations of the general physical, dental, and mental health, growth, development, and nutritional status of children under age twenty-one (21), provided according to guidance for child wellness exams published in the Medicaid General Provider and Participant Handbook; ()

ii. Immunizations recommended by the American Academy of Pediatrics immunization schedule; ()

iii. Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms. ()

c. When prior authorization has been approved according to Section 883 of these rules, treatment services to control, correct, or ameliorate health problems found through diagnosis and screenings; ()

d. If the claim is for prenatal or preventative pediatric care as described in Subsection 215.05.b of this rule, the Department will make payment for the service provided in its fee schedule and will seek reimbursement from the third party according to 42 U.S.C. 1396a(a)(25)(E). ()

06. **Accident Determination.** When the participant's Medicaid card indicates private insurance and/or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until it can be determined that there is no other source of payment. (3-30-07)

07. **Third Party Payments.** The Department will pay the provider the lowest amount of the following: (3-29-12)

a. The provider's actual charge for the service; or (3-29-12)

b. The maximum allowable charge for the service as established by the Department in its pricing file. If the service or item does not have a specific price on file, the provider must submit supporting documentation to the Department. Reimbursement will be based on the documentation; or (3-29-12)

c. The third party-allowed amount minus the third party payment, or the patient liability as indicated by the third party. (3-29-12)

08. **Subrogation of Third Party Liability.** In all cases where the Department will be required to pay medical expenses for a participant and that participant is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the

third party. (3-30-07)

a. If litigation or a settlement in such a claim is pursued by the medical assistance participant, the participant must notify the Department. (3-30-07)

b. If the participant recovers funds, either by settlement or judgment, from such a third party, the participant must repay the amount of benefits paid by the Department on his behalf. (3-30-07)

09. Subrogation of Legal Fees. (3-30-07)

a. If a medical assistance participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept in compromise of its claim, will be reduced by an amount which bears the same relation to the total amount of attorney fees and court costs actually paid by the participant as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the participant. (3-30-07)

b. If a settlement or judgment is received by the participant which does not specify portion of the settlement or judgment which is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the participant in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the participant. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

These rule changes are needed to align with and implement new requirements in federal regulations that went into effect March 17, 2014, for Idaho's Home and Community Based Services (HCBS) offered through the State Plan, and under the authority of the HCBS 1915(c) waiver and the 1915(i) State Plan Option. The purpose of the regulations is to enhance participants' opportunity to receive services in the most integrated settings appropriate, and to increase their opportunities for choice and access to the benefits of community living.

New rules pertaining to Home and Community Based Services are being added to this chapter to ensure that participants receiving HCBS live in and receive services in settings that comply with required qualities of settings, service delivery methods, and person-centered planning processes.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 290-343](#).

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

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, Stephanie Perry at (208) 364-1878.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Monday, October 19, 2015 10:00 a.m. (MDT)	Monday, October 19, 2015 2:00 p.m. (MDT)	Tuesday, October 20, 2015 1:30 p.m. (PDT)
Medicaid Central Office 3232 W. Elder Street Conference Room D -- West/East Boise, ID	Medicaid Region VII Office 150 Shoup Ave., Suite 20 Large Conference Room Idaho Falls, ID	Medicaid Region II Office 1118 "F" Street 2nd Floor Conference Room Coeur d'Alene, ID

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

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

These rule changes are needed to align with and implement new requirements in federal regulations that went into effect March 17, 2014, for Idaho's Home and Community Based Services (HCBS) offered through the State Plan, and under the authority of the HCBS 1915(c) waiver and the 1915(i) State Plan Option. The purpose of the regulations is to enhance participants' opportunity to receive services in the most integrated settings appropriate, and to increase their opportunities for choice and access to the benefits of community living.

New rules pertaining to Home and Community Based Services are being added to this chapter to ensure that participants receiving HCBS live in and receive services in settings that comply with required qualities of settings, service delivery methods, and person-centered planning processes.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

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 June 3, 2015, Idaho Administrative Bulletin, [Vol. 15-6, pages 45-46](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Stephanie Perry at (208) 364-1878.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

LSO Rules Analysis Memo

Italicized red text that is double underscored is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1501

011. DEFINITIONS: E THROUGH K.

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

01. Educational Services. Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services; and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. (3-19-07)

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (4-4-13)

b. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated

by, nor is otherwise a part of a licensed hospital. (3-19-07)

c. “Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)” means an entity as defined in Subsection 011.30 in this rule. (4-4-13)

d. “Nursing Facility (NF)” means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

e. “Rural Hospital-based Provider” means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

f. “Rural Hospital-based Behavioral Care Unit” means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (4-4-13)

g. “Skilled Nursing Facility” means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a “Nursing Facility” under Title XVIII. (3-19-07)

h. “Urban Hospital-based Nursing Facility” means a hospital-based nursing facility located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (5-8-09)

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

11. Funded Depreciation. Amounts deposited or held which represent recognized depreciation. (3-19-07)

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects’ fees, and engineering studies. (3-19-07)

16. Home and Community Based Services (HCBS). HCBS are those long-term services and supports that assist eligible participants to remain in their home and community. ()

167. ICF/ID Living Unit. The physical structure that an ICF/ID uses to house patients. (3-19-07)

~~178~~ 188. Improvements. Improvements to assets which increase their utility or alter their use. (3-19-07)

~~189~~ 189. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

- a.** Activities; (3-19-07)
- b.** Administrative and general care costs; (3-19-07)
- c.** Central service and supplies; (3-19-07)
- d.** Dietary (non-“raw food” costs); (3-19-07)
- e.** Employee benefits associated with the indirect salaries; (3-19-07)
- f.** Housekeeping; (3-19-07)
- g.** Laundry and linen; (3-19-07)
- h.** Medical records; (3-19-07)
- i.** Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)
- j.** Plant operations and maintenance (excluding utilities). (3-19-07)

~~1920~~ 1920. Inflation Adjustment. The cost used in establishing a nursing facility’s prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

~~201~~ 201. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

~~212~~ 212. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

~~223~~ 223. Inspection of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

- a.** At least one (1) registered nurse; and (3-19-07)
- b.** One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: (3-19-07)
 - i.** A consultant physician; or (3-19-07)
 - ii.** A consultant social worker; or (3-19-07)
 - iii.** When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (3-19-07)

~~234~~ 234. Instrumental Activities of Daily Living (IADL). Those activities performed in supporting the

activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

245. Interest. The cost incurred for the use of borrowed funds. (3-19-07)

256. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

267. Interest on Working Capital. The costs incurred for borrowing funds which will be used for “working capital” purposes. These costs are reported under administrative costs. (3-19-07)

278. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/ID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

289. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

2930. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

301. Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). An entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

342. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.

Individuals who are eligible for the Medicaid Enhanced Plan Benefits are eligible for all benefits covered under IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” In addition to those benefits, individuals in the enhanced plan are eligible for the following enhanced benefits as provided for in this chapter of rules. (4-11-15)

01. Dental Services. Dental Services are provided as described under Sections 080 through 089 of these rules. (3-29-12)

02. Enhanced Hospital Benefits. Organ transplants are provided under the Enhanced Hospital services as described in Sections 090 through 099 of these rules. (3-19-07)

03. Enhanced Outpatient Behavioral Health Benefits. Enhanced Outpatient Behavioral Health services are described in IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” (3-20-14)

04. Enhanced Home Health Benefits. Private Duty Nursing services are provided under the Enhanced Home Health as described in Sections 200-219 of these rules. (3-19-07)

05. Therapies. Physical, Speech, and Occupational Therapy Providers as described in Section 215 of these rules. (3-19-07)

06. Long Term Care Services. The following services are provided under the Long Term Care Services. (3-30-07)

- a. Nursing Facility Services as described in Sections 220 through 299 of these rules. (3-19-07)
- b. Personal Care Services as described in Sections 300 through 308 of these rules. (3-30-07)
- c. A & D Wavier Services as described in Sections 320 through 330 of these rules. (3-30-07)
- 07. **Hospice.** Hospice services as described in Sections 450 through 459 of these rules. (3-19-07)
- 08. **Developmental Disabilities Services.** (3-19-07)
 - ~~a.~~ *Developmental Disability Standards as described in Sections 500 through 506 of these rules.* (3-19-07)
 - ~~b.~~ Children's Developmental Disability Services as described in Sections 520 through 528, 660 through 666, and 680 through 686 of these rules. (7-1-13)
 - ~~b.~~ Adult Developmental Disabilities Services as described in Sections 507 through 520~~19~~, and 649~~5~~ through 657, and 700 through 706 of these rules. (7-1-13)()
 - ~~c.~~ ICF/ID as described in Sections 580 through 649 of these rules. (3-19-07)
 - ~~e.~~ *Developmental Disabilities Agencies as described in Sections 700 through 719 of these rules.* (3-19-07)
- 09. **Service Coordination Services.** Service coordination as described in 720 through 779 of these rules. (3-19-07)
- 10. **Breast and Cervical Cancer Program.** Breast and Cervical Cancer Program is described in Sections 780 through 800 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

302. PERSONAL CARE SERVICES: ELIGIBILITY.

- 01. **Financial Eligibility.** The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)
- 02. **Other Eligibility Requirements.** Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-19-07)
 - a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)
 - b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed, or a child for whom a children's PCS assessment has been completed; (3-29-10)
 - c. The RMS reviews the documentation for medical necessity; and (4-2-08)
 - d. The participant has a plan of care that meets the person-centered planning requirements described in Sections 316 and 317 of these rules. (4-2-08)()
- 03. **State Plan Option.** A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds he requires PCS due to a medical condition that impairs his physical or mental function or independence. (3-19-07)

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. (3-19-07)

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QIDP, or the physician. (4-2-08)

b. The medical redetermination must assess the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

304. PERSONAL CARE SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (3-19-07)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: (3-29-10)

i. The physician's or authorized provider's information if applicable; (4-2-08)

ii. The results of the UAI for adults, the children's PCS assessment and, if applicable, the QIDP's assessment and observations of the participant; and (3-29-10)

iii. Information obtained from the participant. (3-19-07)

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. (3-19-07)

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. (3-19-07)

d. The plan of care or NSA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. ()

02. Service Supervision. The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Intellectual Disabilities Professional (QIDP). The RMS must identify the need for supervision. (3-19-07)

a. Oversight must include all of the following: (3-19-07)

i. Assistance in the development of the written plan of care; (3-19-07)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

iii. Reevaluation of the plan of care as necessary; and (3-19-07)

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-19-07)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the RMS, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight must include: (3-19-07)

i. Assistance in the development of the plan of care for those aspects of active treatment which are provided in the participant's personal residence by the personal assistant; (3-19-07)

ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-19-07)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. (3-19-07)

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: (3-29-10)

a. The children's PCS assessment or Uniform Assessment Instrument (UAI) for adults; (3-29-10)

b. The individual service plan developed by the Personal Assistance Agency; and (3-29-10)

c. Any other medical information that supports the medical need. (3-29-10)

04. PCS Record Requirements for a Participant in His Own Home. The PCS records must be maintained on all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. (3-29-10)

a. Written Requirements. The PCS provider must maintain written documentation of every visit made to the participant's home and must record the following minimum information: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Length of visit; (3-19-07)

iii. Services provided during the visit; and (3-19-07)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The RMS may waive this requirement if it determines the participant is not able to verify the service delivery. (3-19-07)

c. Provider Signature. The Plan of Care must be signed by the provider indicating that they will deliver services according to the authorized service plan and consistent with home and community based requirements. ()

~~ed.~~ Copy Requirement. A copy of the information required in Subsection 304.04 of these rules must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. ~~(3-19-07)~~()

~~de.~~ Telephone Tracking System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.04 of these rules. (3-19-07)

~~e.~~ Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (3-19-07)

~~f.~~ Participant in a Certified Family Home. The PCS record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (3-19-07)

05. PCS Record Requirements for a Participant in a Residential Care or Assisted Living Facility or Certified Family Home. The PCS records must be maintained on all participants who receive PCS in a Residential Care or Assisted Living Facility or Certified Family Home. ()

a. Participant in a Residential Care or Assisted Living Facility. The additional PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." ()

b. Participant in a Certified Family Home. The additional PCS record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." ()

c. Participant's Signature. The participant or legal guardian must sign the NSA agreeing to the delivery of services as specified. ()

d. Provider Signature. The NSA must be signed by the supervisory nurse or agency personnel responsible for developing the NSA with the participant, and must indicate that they will deliver services according to the authorized NSA and consistent with home and community-based requirements. ()

~~056.~~ **Provider Responsibility for Notification.** The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

308. PERSONAL CARE SERVICES (PCS): QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies, Residential Care or Assisted Living Facilities, and Certified Family Homes furnishing PCS are responsible for assuring that they provide quality services in compliance with applicable rules. ~~(3-19-07)~~()

02. Review Results. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (3-19-07)

03. Quality Improvement Plan. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report

the results to the Department upon request.

(3-19-07)

04. HCBS Compliance. *Personal Assistance Agencies are responsible for ensuring they meet the setting requirements described in Section 313 of these rules. Residential Care or Assisted Living Facilities, and Certified Family Homes are responsible for ensuring that they meet the setting requirements described in Sections 313 and 314 of these rules. All providers furnishing PCS are responsible for ensuring they meet the person-centered planning requirements described in Sections 316 through 317 of these rules. PCS providers must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation.* ()

309. (RESERVED)

SUB AREA: HOME AND COMMUNITY BASED SERVICES

(Sections 310 - 317)

310. HOME AND COMMUNITY BASED SERVICES.

Home and Community Based Services (HCBS) are those long-term services and supports that assist eligible participants to remain in their home and community. The federal authorities under 42 CFR 441.301, 42 CFR 441.710, and 42 CFR 441.725 require the state to deliver HCBS in accordance with the rules described in Sections 310 through 318 of these rules. HCBS include the following: ()

01. Children's Developmental Disability Services. *Children's developmental disability services as defined in Sections 663 and 683 of these rules.* ()

02. Adult Developmental Disability Services. *Adult developmental disability services as defined in Sections 645 through 659, 703, and 705 of these rules.* ()

03. Consumer-Directed Services. *Consumer-directed services as defined in IDAPA 16.03.13, "Consumer-Directed Services."* ()

04. Aged and Disabled Waiver Services. *Aged and disabled waiver services as defined in Section 326 of these rules.* ()

05. Personal Care Services. *Personal care services as defined in Section 303 of these rules.* ()

311. HCBS REQUIREMENTS AND DECISION-MAKING AUTHORITY.

HCBS requirements, contained in Sections 312 through Sections 317 of these rules, do not supersede decision-making authority legally assigned to another individual or entity on the participant's behalf. This includes: ()

01. Payee. *A representative payee appointed by the Social Security Administration;* ()

02. Restrictions (Probation or Parole). *Court-imposed restrictions related to probation or parole;* ()

03. Restrictions (When Committed). *Court-imposed restrictions when committed to the Director of Health and Welfare; and* ()

04. Legal Guardians Who Retain Full Decision-making Authority. *It is presumed that the parent or parents of participants birth through seventeen (17) years of age have full decision-making authority unless the minor child has another legally assigned decision-making authority.* ()

312. HOME AND COMMUNITY BASED SETTINGS.

Home and community based settings include all locations where participants who receive HCBS live or receive their

services. ()

01. Home and Community Based Settings Not Included. Home and community based settings do not include the following: ()

a. A nursing facility: ()

b. An institution for mental diseases: ()

c. An intermediate care facility for persons with intellectual disabilities (ICF/ID): ()

d. A hospital; or ()

e. Any other location that has the qualities of an institutional setting. These institutional qualities include: ()

i. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; or ()

ii. A building on the grounds of, or immediately adjacent to, a state or federally operated inpatient treatment facility; or ()

iii. Any setting that has the effect of isolating participants receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. ()

313. REQUIRED HOME AND COMMUNITY BASED QUALITIES.

Home and community based settings must support eligible participants to have the same opportunities for integration, independence, choice, and rights as individuals who do not require supports or services to remain in their home or community. *If a setting requirement described in this rule presents a health or safety risk to the participant or those around the participant, goals must be identified with strategies to mitigate the risk. These goals and strategies must be documented in the person-centered plan.* Providers must develop and implement policies and procedures to address the following HCBS setting requirements. ()

01. Required Home and Community Based Qualities. Home and community based settings are required to have the following qualities: ()

a. Integration and Access. The setting is integrated in and supports full access to the greater community for participants receiving HCBS. Typical, age-appropriate activities include opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals who do not require supports or services to remain in their home or community. ()

b. Selection of Setting. Home and community based settings are selected by the participant or the participant's decision-making authority from among disability-specific and non-disability-specific settings, and are based on the participant's needs and preferences including consideration of the participant's safety and the safety of those around the participant. ()

c. Participant Rights. The setting ensures a participant's rights of privacy, dignity, and respect, and freedom from coercion and unauthorized restraint are honored. ()

d. Autonomy and Independence. The setting optimizes, but does not regiment, an individual's initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact. ()

e. Choice. The setting promotes opportunities for participant choice regarding the services and supports provided in the setting. ()

02. Services Delivered in the Participant's Own Home. It is presumed that services delivered in the participant's own home, that is not a provider-owned or controlled residence, meet the HCBS setting requirements described in this rule. Providers may not impose restrictions on HCBS setting qualities in a participant's own home without goals and strategies to mitigate risk described in this rule that have been agreed to through the person-centered planning process. ()

314. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.

In addition to the setting requirements described in Section 313 of these rules, provider-owned or controlled settings, including Residential Care or Assisted Living Facilities and Certified Family Homes that provide services to HCBS participants, must also meet the following conditions: ()

01. Written Agreement. A lease, residency agreement, admission agreement, or other form of written agreement will be in place for each HCBS participant at the time of occupancy. The lease or residency agreement must provide protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. ()

02. Privacy. Participants have the right to privacy within their residence. Each participant must have privacy in their sleeping or living unit to include the following: ()

a. The right to entrance doors which are lockable by the individual, with only appropriate staff having keys to doors. ()

b. Participants sharing units have a choice of roommates in that setting. ()

03. Décor. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. ()

04. Schedules and Activities. Participants have the freedom and support to control their own schedules and activities. ()

05. Access To Food. Participants have access to food at any time. ()

06. Visitors. Participants are able to have visitors of their choosing at any time in accordance with the applicable requirements under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." ()

07. Accessibility. The setting is physically accessible to the participant. ()

315. EXCEPTIONS TO RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.

Exceptions to residential setting requirements outlined in Section 314 of these rules must be made based on the needs of the participant that are identified through person-centered planning. Service plans with exceptions to residential setting requirements must be submitted to the Department or its designee for review and approval. When an exception is made, the following information must be documented in the person-centered service plan: ()

01. Assessed Needs. Specific and individualized assessed needs that are related to the exception. ()

02. Interventions and Supports. Positive interventions and supports used prior to any exceptions to the person-centered service plan. ()

03. Prior Methods. List less intrusive methods previously implemented that were unsuccessful in addressing the needs of the participant. ()

04. Description of Intervention. A clear description of the intervention for the exception that is directly proportionate to the specific assessed needs. ()

05. Data Collection. Regular collection and review of data to measure the ongoing effectiveness of the exception. ()

06. Time Limits. Established time limits for periodic reviews to determine if the exception is still necessary, if a transition plan can be developed, or if the exception can be terminated. ()

07. Informed Consent. Informed consent of the participant or legal guardian for the exception. ()

08. Assurance of No Harm. An assurance that interventions and supports will cause no harm to the participant. ()

316. HOME AND COMMUNITY BASED PERSON-CENTERED PLANNING REQUIREMENTS.

All participants *or their decision-making authority* must direct the development of their service plan through a person-centered planning process. Information and support must be given to the HCBS participant to maximize their ability to make informed choices and decisions. Individuals invited to participate in the person-centered planning process should be identified by the participant *or the participant's decision-making authority*. Legal guardians who do not have full decision-making authority as described in Section 311 of these rules will have a participatory role as needed and defined by the participant. The person-centered planning process must: ()

01. Timely and Convenient. Be conducted timely and occur at convenient times and locations to the participant *and the participant's decision-making authority in accordance with program requirements*. ()

02. Cultural Considerations. Reflect cultural considerations of the participant. ()

03. In Plain Language and Accessible. Be conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and persons who are limited English proficient as defined in 42 CFR 435.905(b). ()

04. Conflict Resolution. Utilize strategies for solving conflict or disagreement within the process, and follow clear conflict-of-interest guidelines for all planning participants. ()

317. HOME AND COMMUNITY BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS.

All person-centered service plans must reflect the following components: ()

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. ()

02. Service Delivery Preferences. Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports. ()

03. Setting Selection. HCBS settings selected by the participant *or the participant's decision-making authority* are chosen from among a variety of setting options, *as required in Section 313 of these rules*. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, *or the participant's decision-making authority*. ()

04. Participant Strengths and Preferences. ()

05. Individually Identified Goals and Desired Outcomes. ()

06. Paid and Unpaid Services and Supports. Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. ()

07. Risk Factors. Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed. ()

08. Understandable Language. Be understandable to the participant receiving services and supports. ()

and the individuals important in supporting him or her. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). ()

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. ()

10. Plan Signatures. Be finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community based requirements. ()

a. Children's DD service providers responsible for implementation of the plan include the providers of those services defined in Sections 663 and 683 of these rules. ()

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. ()

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency as identified in IDAPA 16.03.13, "Consumer-Directed Services." ()

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services defined in Sections 303 and 326 of these rules. ()

11. Plan Distribution. Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. At a minimum, the following providers will receive a copy of the plan: ()

a. Children's DD providers of services defined in Sections 663 and 683 of these rules as identified on the plan of service developed by the family-centered planning team. ()

b. Adult DD service providers required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. ()

c. Consumer-Directed service providers as defined in IDAPA 16.03.13, "Consumer-Directed Services," Section 110. Additionally, the participant, or the participant's decision-making authority will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors. ()

d. Personal Care and Aged and Disabled Waiver service providers furnishing those services defined in Sections 303 and 326 of these rules. ()

12. Residential Requirements. For participants living in residential provider owned or controlled settings as described in Section 314 of these rules, the following additional requirements apply: ()

a. Options described in Subsection 317.03 of this rule must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. ()

b. Any exception to residential provider owned or controlled setting qualities as described in Section 314 of these rules must be documented in the person-centered plan as described in Section 315 of these rules. ()

318. HCBS TRANSITION PLAN.

As required by the Department, all current providers of HCBS must complete a Department-approved self assessment form related to the setting requirements and qualities described in Sections 311 through 314 of these rules. ()

01. Provider Transition Plan. *As part of the self-assessment process, providers not in compliance with any portion of the new requirements and qualities must develop a plan for coming into compliance. Self-assessment forms are subject to review and validation by the Department via quality assurance activities.* ()

02. New HCBS Providers or Service Settings. New HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. ()

03. Quality Assurance. The Department will begin enforcement of quality assurance compliance with Sections 311 through 314 of these rules on January 1, 2017. ()

~~309.~~ 319. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by Department staff or a contractor. The Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (4-4-13)

a. Services that are not in the individual service plan approved by the Department or its contractor are not eligible for Medicaid payment. (4-4-13)

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (3-19-07)

c. The earliest date that services may be approved by the Department or its contractor for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (4-4-13)

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-19-07)

a. The UAI; (3-19-07)

b. The individual service plan developed by the Department or its contractor; and (3-19-07)

c. Any other medical information which verifies the need for nursing facility services in the absence of the waiver services. (3-19-07)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department or its contractor. (4-4-13)

04. Individual Service Plan. All waiver services must be authorized by the Department or its contractor in the Region where the participant will be residing and services provided based on a written individual service plan. (4-4-13)

a. The initial individual service plan is developed by the Department or its contractor, based on the UAI, in conjunction with: (4-4-13)

i. The waiver participant (with efforts made by the Department or its contractor to maximize the participant's involvement in the planning process by providing him with information and education regarding his

- rights); (4-4-13)
- ii. The guardian, when appropriate; (3-30-07)
 - iii. The supervising nurse or case manager, when appropriate; and (3-19-07)
 - iv. Others identified by the waiver participant. (3-19-07)
- b.** The individual service plan must include the following: (3-19-07)
- i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)
 - ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-30-07)
 - iii. The providers of waiver services when known; (3-30-07)
 - iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-19-07)
 - v. The signature of the participant or his legal representative, agreeing to the plan. (3-19-07)
- c.** The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-19-07)
- d.** All services reimbursed under the Aged and Disabled Waiver must be authorized by the Department or its contractor prior to the payment of services. (4-4-13)
- e.** The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the Department or its contractor. (4-4-13)
- 05. Service Delivered Following a Written Plan of Care.** All services that are provided must be based on a written plan of care. (3-30-07)
- a.** The plan of care is developed by the plan of care team which includes: (3-30-07)
 - i. The waiver participant with efforts made to maximize his participation on the team by providing him with information and education regarding his rights; (3-30-07)
 - ~~ii.~~ ~~The Department's administrative case manager;~~ ~~(3-30-07)~~
 - ~~ii.~~ The guardian when appropriate; (3-30-07)
 - ~~i+ii.~~ Service provider identified by the participant or guardian; and (3-30-07)
 - ~~iv.~~ May include others identified by the waiver participant. (3-30-07)
 - b.** The plan of care must be based on an assessment process approved by the Department. (3-30-07)
 - c.** The plan of care must include the following: (3-30-07)
 - i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)
 - ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (3-30-07)

- iii. The providers of waiver services; (3-30-07)
 - iv. Goals to be addressed within the plan year; (3-30-07)
 - v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (3-30-07)
 - vi. The signature of the participant or his legal representative. (3-30-07)
 - vii. *The signature of the agency or provider indicating that they will deliver services according to the authorized service plan and consistent with home and community based requirements.* ()
 - d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-30-07)
 - e. The Department's ~~case manager~~ Nurse Reviewer monitors the plan of care and all waiver services. (3-30-07) ()
 - f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (3-30-07)
- 06. Individual Service Plan and Written Plan of Care.** The development and documentation of the individual service plan and written plan of care must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. ()
- 067. Provider Records.** Records will be maintained on each waiver participant. (3-19-07)
- a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)
 - i. Date and time of visit; (3-19-07)
 - ii. Services provided during the visit; (3-19-07)
 - iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)
 - iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the Department or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (4-4-13)
 - b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the Department. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (4-4-13)
 - c. The individual service plan initiated by the Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. (4-4-13)
 - d. Record requirements for participants in residential care or assisted living facilities are described in

IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

e. Record requirements for participants in certified family homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-4-13)

~~078.~~ Provider Responsibility for Notification. The service provider is responsible to notify the Department or its contractor, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (4-4-13)

~~089.~~ Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-19-07)

~~109.~~ Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (3-19-07)

329. AGED AND DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; (3-19-07)

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker services, respite care, adult day health,

transportation, chore services, companion services, attendant care, adult residential care, 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 Aged and Disabled waiver as approved by CMS. (4-4-13)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

04. Quality Assurance. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. ()

a. The results of a quality assurance review conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. ()

b. The provider must respond to the quality assurance review within forty-five (45) days after the results are received from the Department. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. ()

c. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ()

05. HCBS Setting Compliance. Providers of Aged and Disabled waiver services are responsible for ensuring that they meet the person-centered planning and setting quality requirements described in Sections 311 through 318 of these rules, as applicable, and must comply with associated Department quality assurance activities. ()

046. Specialized Medical Equipment and Supplies. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. (4-4-13)

057. Skilled Nursing Service. Skilled nursing service providers must be licensed in Idaho as a registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

068. Consultation Services. Consultation services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (4-4-13)

079. Adult Residential Care. Adult residential care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," or IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)

108. Home Delivered Meals. Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure that: (4-4-13)

- a.** Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (4-4-13)
- b.** Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (4-4-13)
- c.** Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; (4-4-13)
- d.** The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments"; (4-4-13)
- e.** A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (4-4-13)
- f.** Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met. (4-4-13)

~~10~~11. Personal Emergency Response Systems. Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. (4-4-13)

~~10~~2. Adult Day Health. Providers of adult day health must meet the following requirements: (4-4-13)

- a.** Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (4-4-13)
- b.** Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-4-13)
- c.** Services provided in a residential adult living facility must be provided in a residential adult living facility that meets the standards identified in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-4-13)
- d.** Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)
- e.** Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. (4-4-13)
- f.** Adult day health providers who provide direct care or services must be free from communicable disease. (4-4-13)
- g.** All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

~~14~~3. Non-Medical Transportation Services. Providers of non-medical transportation services must: (4-4-13)

- a.** Possess a valid driver's license; (4-4-13)
- b.** Possess valid vehicle insurance; and (4-4-13)

c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

124. Attendant Care. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

135. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

146. Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (4-4-13)

157. Residential Habilitation Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a residential habilitation agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (4-4-13)

- a. Direct service staff must meet the following minimum qualifications: (3-30-07)
 - i. Be at least eighteen (18) years of age; (3-30-07)
 - ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (4-4-13)
 - iii. Have current CPR and First Aid certifications; (3-30-07)
 - iv. Be free from communicable disease; (4-4-13)
 - v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)
 - vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-4-13)
 - vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)
- b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. (4-4-13)
- c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (4-4-13)

- i. Purpose and philosophy of services; (3-30-07)
- ii. Service rules; (3-30-07)
- iii. Policies and procedures; (3-30-07)
- iv. Proper conduct in relating to waiver participants; (3-30-07)
- v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)
- vi. Participant rights; (3-30-07)
- vii. Methods of supervising participants; (3-30-07)
- viii. Working with individuals with traumatic brain injuries; and (3-30-07)
- ix. Training specific to the needs of the participant. (3-30-07)
- d.** Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)
 - i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)
 - ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)
 - iii. Feeding; (3-30-07)
 - iv. Communication; (3-30-07)
 - v. Mobility; (3-30-07)
 - vi. Activities of daily living; (3-30-07)
 - vii. Body mechanics and lifting techniques; (3-30-07)
 - viii. Housekeeping techniques; and (3-30-07)
 - ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)
- e.** The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (4-4-13)

168. Day Habilitation. Providers of day habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

179. Respite Care. Providers of respite care services must meet the following minimum qualifications: (4-4-13)

- a.** Have received care giving instructions in the needs of the person who will be provided the service; (4-4-13)
- b.** Demonstrate the ability to provide services according to a plan of service; (4-4-13)

- c. Be free of communicable disease; and (4-4-13)
- d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

4820. Supported Employment. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." Providers must also take a traumatic brain injury training course approved by the Department. (4-4-13)

219. Chore Services. Providers of chore services must meet the following minimum qualifications: (4-4-13)

- a. Be skilled in the type of service to be provided; and (4-4-13)
- b. Demonstrate the ability to provide services according to a plan of service. (4-4-13)
- c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)
- d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.

For the purposes of these rules the following terms are used as defined below. (3-29-12)

- 01. Adult.** A person who is eighteen (18) years of age or older. (3-29-10)
- 02. Assessment.** A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)
- 03. Clinical Review.** A process of professional review that validates the need for continued services. (3-19-07)
- 04. Community Crisis Support.** Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)
- 05. Concurrent Review.** A clinical review to determine the need for continued prior authorization of services. (3-19-07)
- 06. Exception Review.** A clinical review of a plan that falls outside the established standards. (3-19-07)
- 07. Interdisciplinary Team.** For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)

- 08. Level of Support.** An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)
- 09. Person-Centered Planning Process.** A meeting facilitated by the participant or plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. ~~(3-19-07)~~ ()
- 10. Person-Centered Planning Team.** The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)
- 11. Plan Developer.** A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)
- 12. Plan Monitor.** A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)
- 13. Plan of Service.** An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)
- 14. Prior Authorization (PA).** A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)
- 15. Provider Status Review.** The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)
- 16. Right Care.** Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)
- 17. Right Place.** Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)
- 18. Right Price.** The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)
- 19. Right Outcomes.** Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)
- 20. Service Coordination.** Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)
- 21. Service Coordinator.** An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)
- 22. Services.** Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)
- 23. SIB-R.** The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-19-07)

24. **Supports.** Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.

In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-29-12)

01. **Qualifications of a Paid Plan Developer.** Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. **Plan Development.** ~~The plan must be developed with the participant. With the participant's consent, the person-centered planning team~~ All participants must direct the development of their service plan through a person-centered planning process. Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes. ()

a. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-19-07)()

b. The plan development process must meet the person-centered planning requirements described in Section 316 of these rules. ()

c. The participant may facilitate his own person-centered planning meeting, or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant. ()

03. **Prior Authorization Outside of These Rules.** The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services. (7-1-13)

04. **No Duplication of Services.** The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-29-12)

05. **Plan Monitoring.** The participant, service coordinator or plan monitor must monitor the plan. The

plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

- a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)
- b. Contact with service providers to identify barriers to service provision; (3-19-07)
- c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)
- d. Review of provider status reviews. (3-29-12)
- e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-29-12)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.409 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-19-07)()

- a. The status of supports and services to identify progress; (3-19-07)
- b. Maintenance; or (3-19-07)
- c. Delay or prevention of regression. (3-19-07)

07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

a. The written plan of service must meet the person-centered planning requirements described in Section 317 of these rules. ()

b. The written plan of service must be finalized and agreed to according to procedural requirements described in Section 704 of these rules. ()

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other developmental disability service provider identified by the participant during the person-centered planning process. ()

08. Informed Consent. Unless the participant has a guardian ~~with appropriate~~ who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have 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. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If ~~not~~, 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 plan or amendment ~~must~~ may be referred to the Bureau of ~~Care Management's Medicaid Consumer Relations Specialist~~ Developmental Disability Services to negotiate a resolution with members of the planning team. (3-19-07)()

09. Provider Implementation Plan. Each provider of Medicaid services, ~~subject to prior~~

~~authorization~~, must develop an implementation plan that complies with home and community based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service. ~~(3-19-07)~~()

- a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)
 - i. Specialized medical equipment; (3-19-07)
 - ii. Home delivered meals; (3-19-07)
 - iii. Environmental ~~modifications~~ accessibility adaptations; ~~(3-19-07)~~()
 - iv. Non-medical transportation; (3-19-07)
 - v. Personal emergency response systems (PERS); (3-19-07)
 - vi. Respite care; and (3-19-07)
 - vii. Chore services. (3-19-07)

b. Time for Completion. ~~The~~ Implementation plans must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change of receipt of the authorized plan of service or the service start date, whichever is later. ~~(3-19-07)~~()

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. ()

ii. Implementation plan revision must be based on changes to the needs of the participant. ()

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

10. Home and Community Based Services Plan of Service Signature. Upon receipt of the authorized plan of service, HCBS providers responsible for the implementation of the plan as identified in Section 317 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community based requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Documentation of signature must include the signature of the professional responsible for service provision complete with their title and the date signed. Provider signature will be completed each time an initial or annual plan of service is implemented. ()

101. Addendum to the Plan of Service. ()

a. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ~~(3-29-12)~~()

b. When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service as identified in Section 317 of these rules. ()

c. Upon receipt of the addendum, the HCBS 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 complete with their title and the date signed, and must be maintained in the participant's record. Provider signature will be completed each time an addendum is authorized. (3-19-07)

~~11. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period.~~ (3-19-07)

~~a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community.~~ (3-19-07)

~~b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future.~~ (3-19-07)

~~c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days.~~ (3-19-07)

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d.06 of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service; inviting individuals to participate that have been identified by the participant. (3-19-07)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-29-12)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.120 of these rules. (3-19-07)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

13. Complaints and Administrative Appeals. (3-29-12)

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (3-29-12)

b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. **Quality Assurance.** Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may ~~terminate authorization of service for providers who do not comply with the corrective action plan~~ take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation. (3-19-07)()

02. **Quality Improvement.** The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, participant experience related to home and community based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (3-19-07)()

03. **Exception Review.** The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following conditions are met: (4-11-15)

a. Services are needed to assure the health and safety of participants who require residential high or intense supported living, and the services requested on the plan or addendum are required based on medical necessity as defined in Subsection 012.14 of these rules. (4-11-15)

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: (4-11-15)

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; (4-11-15)

ii. The participant's plan of service was developed by the participant and his person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's combination of services must support the increase or addition of supported employment services; and (4-11-15)

iii. An acknowledgement signed by the participant and his legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. (4-11-15)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. (3-19-07)()

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-19-07)

516. -- 519. (RESERVED)

SUB-PART: CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION
(Sections 520 - 528)

520. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA).

The purpose of the children's DD Prior Authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of service, prior approval of services, and a quality improvement program. Prior authorization is intended to help ensure the provision of necessary and appropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for HCBS as described in Section 310 through 317 of these rules, and for the specific services included on the plan. Delivery of each service identified on the plan of service cannot be initiated until after the plan has been signed by the provider agency professional responsible for service provision. (7-1-11)()

521. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): DEFINITIONS.

For the purposes of Sections 520 through 528 of these rules, the following terms are used as defined below. (7-1-11)

01. Assessment. A process that is described in Section 522 of these rules for program eligibility and in Section 526 of these rules for plan of service. (7-1-11)

02. Baseline. A participant's skill level prior to intervention written in measurable, behaviorally-stated terms. (7-1-11)

03. Child. A person who is under the age of eighteen (18) years. (7-1-11)

04. Family. The participant and his parent(s) or legal guardian. (7-1-11)

05. Family-Centered Planning Process. A participant-focused planning process directed by the participant or the participant's decision-making authority and facilitated by the paid or non-paid plan developer, by which the family-centered planning team collaborates with the participant to develop discusses the participant's strengths, needs, and preferences, including the participant's safety and the safety of those around the participant. This discussion helps the participant or the participant's decision-making authority make informed choices about the services and supports included on the plan of service. (7-1-11)()

06. Family-Centered Planning Team. The planning group who helps inform the participant about available services and supports in order to develop the participant's plan of service. This group includes, at a minimum, the child participant (unless otherwise determined by the family-centered planning team), the participant's

decision-making authority, and the plan developer. If the participant is unable to attend the family-centered planning (FCP) meeting, the Plan of Service must contain documentation to justify the participant's absence. The family-centered planning team ~~may~~ must include ~~others identified by people chosen by the participant and~~ the family, or agreed upon by the ~~participant and the~~ family ~~and the Department~~ as important to the process. (7-1-11)()

07. **ICF/ID.** Intermediate care facility for persons with intellectual disabilities. (7-1-11)

08. **Individualized Family Service Plan (IFSP).** An initial or annual plan of service; ~~for providing early intervention services to children from birth to three (3) years of age (thirty-six (36) months old).~~ The plan is developed by ~~the family-centered planning team that includes the child participant, the participant's decision-making authority and other planning team members chosen by the participant's decision-making authority, and~~ the Department or its designee; ~~for providing early intervention services to children from birth up to three (3) years of age (36 months).~~ This plan IFSP must meet the provisions of the Individuals with Disabilities Education Act (IDEA), Part C, and must be developed in accordance with Sections 316 through 317 of these rules. The IFSP may serve as the plan of service if it meets all of the components of the plan of service. The IFSP may also serve as a program implementation plan. (7-1-13)()

09. **Level of Support.** The amount of services and supports necessary to allow the individual to live independently and safely in the community. (7-1-11)

10. **Medical, Social, and Developmental Assessment Summary.** A form used by the Department to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. (7-1-11)

11. **Plan Developer.** A paid or non-paid person ~~identified by the participant~~ who, under the direction of the participant or the participant's decision-making authority, is responsible for developing ~~one (1) a single~~ plan of service and subsequent addenda. The service plan must that cover all services and supports ~~based on a identified during the~~ family-centered planning process and must meet the HCBS person-centered plan requirements as described in Section 317 of these rules. (7-1-11)()

12. **Plan Monitor.** A person who oversees the provision of services on a paid or non-paid basis and is identified on the participant's person-centered plan of service. (7-1-11)()

13. **Plan of Service.** An initial or annual plan of service, developed by the participant, the participant's decision-making authority, and the family-centered planning team, that identifies all services and supports ~~based on that were determined through~~ a family-centered planning process; ~~and which is.~~ The plan developed ~~edment for is required in order to~~ provide DD services to children ~~from~~ birth through seventeen (17) years of age. This plan must be developed in accordance with Sections 316 and 317 of these rules. (7-1-11)()

14. **Practitioner of the Healing Arts, Licensed.** A licensed physician, physician assistant, or nurse practitioner. (7-1-11)

15. **Prior Authorization (PA).** A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by Sections 520 and 528 these rules. (7-1-11)

16. **Provider Status Review.** The written documentation that identifies the participant's progress toward goals defined in the plan of service, and demonstrates the continued need for the service. (7-1-11)

17. **Right Care.** Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (7-1-11)

18. **Right Place.** Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-11)

19. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (7-1-11)

20. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-11)

21. Services. Evaluation, diagnostic, therapy, training, assistance, and support services that are provided to persons with developmental disabilities. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

524. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): COVERAGE AND LIMITATIONS.

The scope of these rules defines prior authorization for the following Medicaid developmental disabilities services for children included in Section 310 of these rules: ~~(7-1-11)~~()

01. Children's Home and Community Based State Plan Option Services. Children's home and community based state plan option services as described in Sections 660 through 666 of these rules; and (7-1-11)

02. Children's DD Waiver Services. Children's DD waiver services as described in Sections 680 through 686 of these rules. (7-1-11)

525. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PROCEDURAL REQUIREMENTS.

Prior to the development of the plan of service, the plan developer will gather and make referrals for the following information to ~~guide~~ facilitate the family-centered planning process: ~~(7-1-11)~~()

01. Eligibility Determination Documentation. Eligibility determination documentation completed by the Department or its contractor as defined in Subsection 522.03 of these rules. (7-1-11)

02. History and Physical. A current history and physical completed by a practitioner of the healing arts is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (7-1-11)

03. Discipline-Specific Assessments. Participants must be referred for an occupational therapy, physical therapy, or speech-language pathology assessment when the participant has a targeted need in one of these disciplines. The assessment is used to guide the provision of services identified on the plan of service. (7-1-11)

04. Additional Information. Gather assessments and information related to the participant's medical conditions, risk of deterioration, living conditions, individual goals, and behavioral or psychiatric needs. (7-1-11)

526. CHILDREN'S DEVELOPMENTAL DISABILITY PRIOR AUTHORIZATION (PA): PLAN OF SERVICE PROCESS.

In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 527 of these rules and must identify all services and supports. The participant and his parent or legal guardian may develop their own plan or use a paid or non-paid plan developer to assist with plan development. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. (7-1-11)

01. Plan Development ~~and Monitoring~~. Paid plan development ~~and monitoring~~ must be provided by the Department or its contractor in accordance with Section 316 of these rules. Non-paid plan development ~~and~~

~~monitoring~~ may be provided by the family, or a person of their choosing, in accordance with the Home and Community Based Services (HCBS) regulations in Section 316 of these rules, when this person is not a paid provider of services identified on the child's plan of service. (7-1-11)()

a. The plan developer is responsible for the documentation of the developed plan and any subsequent plan changes as determined by the family-centered planning team. ()

b. Individuals responsible for facilitating the person-centered planning meeting and developing the plan of service cannot be providers of direct services to the participant. ()

02. Plan of Service Development. The plan of service must meet the requirements described in Section 317 of these rules. The service plan must be developed with ~~the parent or legal guardian, and~~ the child participant, ~~(unless otherwise determined by the family-centered planning team)~~ the participant's decision-making authority, and facilitated by the Department or its designee. If the participant is unable to attend the family-centered planning (FCP) meeting, the Plan of Service must contain documentation to justify the participant's absence. With the ~~parent or legal guardian's decision-making authority's~~ consent, the family-centered planning team may include other family members or individuals who are significant to the participant. (7-1-11)()

a. In developing the plan of service, the family-centered planning team must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. The development of the service plan must be conducted in accordance with the Home and Community Based Services requirements in Section 317 of these rules. (7-1-11)()

b. The plan of service must identify, at a minimum, the type of service to be delivered, goals and desired outcomes to be addressed within the plan year, strengths and preferences of the participant, including the participant's safety and the safety of those around the participant, target dates, and methods for collaboration. (7-1-11)()

03. No Duplication of Services. The plan developer must ensure that there is no duplication of services. (7-1-11)

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months, and document the plan monitor's name along with the monitoring frequency on the plan. The plan developer is considered the plan monitor and must meet face-to-face with the participant and the participant's decision-making authority at least annually. Plan monitoring must include the following: (7-1-11)()

a. Review of the plan of service with the participant and parent or legal guardian the participant's decision-making authority to identify the current status of programs and changes if needed; (7-1-11)()

b. Maintain ~~ce~~ contact with service providers to identify and remediate barriers to service provision; (7-1-11)()

c. Discuss with the participant and his parent or legal guardian decision-making authority their satisfaction regarding quality and quantity of services; and (7-1-11)()

d. Review of provider status reviews for compliance with the plan of service. (7-1-11)()

05. Provider Status Reviews. The service providers in Sections 664 and 684 of these rules must report to the plan monitor the participant's progress toward goals. The provider must complete a six (6) month and annual provider status review. The provider status review must be submitted to the plan monitor within forty-five (45) calendar days prior to the expiration of the existing plan of service. (7-1-11)

06. Informed Consent. The participant and ~~his parent or legal guardian~~ the participant's decision-

making authority must make decisions regarding the type and amount of services required. ()

a. Prior to plan development, the plan developer must document that they have provided information and support to the participant and the participant's decision-making authority to maximize their ability to make informed choices regarding the services and supports they receive and from whom. ()

b. During plan development and amendments, planning team members must ~~each indicate~~ document whether they believe the plan is in accordance with the participant's choices of the services and supports identified in the meeting and whether they believe the plan meets the needs of the participant, ~~and represents the participant's choice.~~ (7-1-11)()

c. If there is a conflict that cannot be resolved among the family-centered planning members or if the participant or the participant's decision-making authority does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with the planning team. ()

07. Program Implementation Plan. Providers of children's waiver services listed under Section 684 of these rules must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (7-1-13)

a. The implementation plan must be completed within fourteen (14) calendar days after the initial provision of service, and revised whenever participant needs change. (7-1-11)

b. Documentation of implementation plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the signature of the person making the change complete with his title and the date signed. (7-1-11)

08. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes that result in the need for an addition or reduction of a service, or a change in a provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service requires a parent's or legal guardian's the decision-making authority's signature and may be subject to prior authorization by the Department. The Department will distribute the addendum to the providers involved in the addendum's implementation. Upon receipt by the provider, the addendum must be reviewed, signed, and returned to the Department, with a copy maintained in the participant's record. (7-1-11)()

09. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (7-1-11)

a. Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules. (7-1-11)

b. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least ten (10) calendar days prior to the expiration date of the current plan. Prior to this, the plan developer must: (7-1-13)

- i. Notify the providers who appear on the plan of service of the annual review date. (7-1-11)
- ii. Obtain a copy of the current annual provider status review from each provider for use by the family-centered planning team. Each provider status review must meet the requirements in Subsection 526.06 of these rules. (7-1-11)
- iii. Convene the family-centered planning team to develop a new plan of service. (7-1-11)

c. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 520 and 526 of these rules. (7-1-11)

d. Adjustments to the Annual Budget and Services. The annual budget may be adjusted when there are documented changes that may support placement in a different budget category as identified in Section 527 of these rules. Services may be adjusted at any time during the plan year. (7-1-13)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after at least a thirty (30) calendar day lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

**528. CHILDREN'S DEVELOPMENTAL DISABILITIES PRIOR AUTHORIZATION (PA):
DEPARTMENT'S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES.**

01. **Quality Assurance.** Quality Assurance consists of audits and reviews to ensure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) calendar days after the results are received. The Department may terminate authorization of service or the provider agreement for providers who do not comply with the corrective action plan. If the Department finds a provider's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may immediately terminate the provider agreement. (7-1-11)

02. **Quality Improvement.** The Department may gather and utilize information from participants and providers to evaluate customer satisfaction, participant satisfaction, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings lead to quality improvement activities to improve provider processes and outcomes for participants. (7-1-11)

03. **Plan of Service Review.** The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, services continue to be clinically necessary, services continue to be the choice of the participant, and services constitute appropriate care to warrant continued authorization or need for the service. (7-1-11)

04. **HCBS Compliance.** Providers of children's developmental disability services are responsible for ensuring that they meet the setting quality requirements described in Section 313 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ()

(BREAK IN CONTINUITY OF SECTIONS)

634. -- ~~6484~~. (RESERVED)

**ADULT DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY
BASED SERVICES (HCBS) STATE PLAN OPTION**
(Sections 645 - 659)

645. HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.
Home and community based services are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with developmental disabilities who do not meet the ICF/ID level of care. HCBS state plan option services must comply with Sections 310 through 318, and Sections 647 through 659 of these rules. ()

646. COMMUNITY CRISIS SUPPORTS.

Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. ()

647. COMMUNITY CRISIS SUPPORTS: ELIGIBILITY.

Prior to receiving community crisis supports, an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. ()

648. COMMUNITY CRISIS SUPPORTS COVERAGE AND LIMITATIONS.

Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. ()

01. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. ()

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. ()

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within seventy-two (72) hours of providing the service. ()

(BREAK IN CONTINUITY OF SECTIONS)

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.

Developmental therapy must be recommended by a physician or other practitioner of the healing arts. (7-1-13)

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an assessment completed prior to the delivery of developmental therapy. (7-1-13)

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-13)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental Therapy may be provided in home and community based settings as described in Section 312 of these rules. Developmental therapy, in both individual and

group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. ~~(7-1-11)~~()

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-13)

02. Excluded Services. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as specified below. (7-1-13)

a. Developmental therapy must not exceed twenty-two (22) hours per week. (7-1-13)

b. Developmental therapy provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. (7-1-13)

c. When a participant receives adult day health as provided in Subsection 703.12 of these rules, the combination of adult day, health and developmental therapy must not exceed thirty (30) hours per week. (7-1-13)

d. Only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

653. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN IPP.

01. Eligibility Determination. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-13)

02. Intake. Individuals using the Home and Community-Based Services (HCBS) waiver for the Aged and Disabled (A&D) or State Plan Personal Care Services and only requesting DDA services, have the option to access services through an Individual Program Plan. Individuals who select this option are not required to have a developmental disability plan developer ~~or an Individual Service Plan~~. Services delivered through an Individual Program Plan must be authorized by the Department or its contractor and be based on the Aged and Disabled written Individual Service Plan as defined in Section 328 of these rules. Prior to the delivery of developmental therapy, a DDA must complete an Individual Program Plan (IPP) that meets the standards described below. ~~(7-1-13)~~()

03. Individual Program Plan (IPP) Definitions. The delivery of developmental therapy on a ~~plan~~ written plan of care must be defined in terms of the type, amount, frequency, and duration of the service. ~~(7-1-13)~~()

a. Type of service refers to the kind of service described in terms of: (7-1-11)

- i. Group, individual, or family; and (7-1-11)
- ii. Whether the service is home, community, or center-based. (7-1-11)
- b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. (7-1-11)
- c. Frequency of service is the number of times service is offered during a week or month. (7-1-11)
- d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. (7-1-11)

04. Individual Program Plan (IPP). (7-1-13)

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. (7-1-11)

b. The planning process must include the participant, his legal guardian if one exists, and others the participant or his legal guardian chooses. The participant and his legal guardian if one exists must sign the IPP indicating ~~participation in its development~~ they directed the person-centered planning process. The participant and his legal guardian if one exists must be provided a copy of the completed IPP by the DDA. ~~If the participant or his legal guardian is unable to participate, the reason must be documented in the participant's record.~~ A physician or other practitioner of the healing arts, the participant, and his legal guardian if one exists, must sign the IPP prior to initiation of any services identified within the plan. (7-1-13)()

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations require written authorization by the participant, his legal guardian if one exists, and must be maintained in the participant's file. (7-1-13)

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. (7-1-11)

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: (7-1-11)

- i. The participant's name and medical diagnosis; (7-1-11)
- ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; (7-1-11)
- iii. The dated signature of the physician or other practitioner of the healing arts indicating his recommendation of the services on the plan; (7-1-11)
- iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; (7-1-11)

v. A list of the participant's current personal goals and desired outcomes, interests, and choices; (7-1-11)()

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences.

An IPP objective must be developed for each priority need; (7-1-11)

vii. A list of measurable behaviorally stated objectives, which correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; (7-1-11)

viii. The Developmental Specialist responsible for each objective; (7-1-13)

ix. The target date for completion of each objective; (7-1-11)

x. The review date; and (7-1-11)

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. (7-1-13)

05. Documentation of Plan Changes. Documentation of required Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: (7-1-13)

a. The reason for the change; (7-1-11)

b. Documentation of coordination with other services providers, where applicable; (7-1-11)

c. The date the change was made; and (7-1-11)

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant and his legal guardian if one exists. Changes in type, amount, or duration of services must be recommended by a physician or other practitioner of the healing arts. Such recommendations require written authorization by the participant and his legal guardian if one exists prior to the change. If the signatures of the participant or his legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. (7-1-13)

06. Home and Community Based Person-Centered Planning. Individual Program Plans completed by a DDA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules and must be included in the participant's individual service plan as described in Section 328 of these rules. ()

654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. DDAs must obtain assessments required under Sections 507 through 515 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: (7-1-13)

a. Comprehensive Developmental Assessment; and (7-1-13)

b. Specific Skill Assessment. (7-1-13)

02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. (7-1-13)

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11)

i. Determine the necessity of the service; (7-1-11)

ii. Determine the participant's needs; (7-1-11)

- iii. Guide treatment; (7-1-11)
- iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)
- b.** Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-11)
- c.** Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. To be considered current, assessments must be completed or updated at least every two (2) years for service areas in which the participant is receiving services on an ongoing basis. (7-1-13)
- d.** Comprehensive Developmental Assessment. A comprehensive developmental assessment must reflect a person's developmental status in the following areas: (7-1-13)
 - i. Self-care; (7-1-11)
 - ii. Receptive and expressive language; (7-1-11)
 - iii. Learning; (7-1-11)
 - iv. Gross and fine motor development; (7-1-11)
 - v. Self-direction; (7-1-11)
 - vi. Capacity for independent living; and (7-1-11)
 - vii. Economic self-sufficiency. (7-1-11)
- 03. Specific Skill Assessments.** Specific skill assessments must: (7-1-13)
 - a.** Further assess an area of limitation or deficit identified on a comprehensive assessment. (7-1-13)
 - b.** Be related to a goal on the IPP or ISP. (7-1-13)
 - c.** Be conducted by qualified professionals. (7-1-13)
 - d.** Be conducted for the purposes of determining a participant's skill level within a specific domain. (7-1-13)
 - e.** Be used to determine baselines and develop the program implementation plan. (7-1-13)
- 04. DDA Program Documentation Requirements.** Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11)
 - a.** General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11)
 - i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-11)
 - ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-11)
 - iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation

procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)

iv. Documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why he continues to need services. (7-1-13)

v. Signed, authorized plan as described in Section 513 of these rules. ()

b. DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. (7-1-13)

05. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be ~~written and implemented~~ developed within fourteen (14) days ~~after the first day of ongoing programming~~ from the plan of service start date or receipt of the authorized plan of service and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. If consistent with the timeframes above, a participant's annual Program Implementation Plan is completed after the start date of the annual plan of service, the provider will address goals and objectives as agreed to by the participant until the annual Program Implementation Plan is complete and must document service provision related to these interim goals and objectives consistent with Section 654 of these rules. The Program Implementation Plan must include the following requirements: (7-1-11)()

a. Name. The participant's name. (7-1-11)

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives ~~previously identified on~~ authorized and agreed to in the required plan of service. (7-1-11)()

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-11)

f. Target Date. Target date for completion. (7-1-11)

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

h. Home and Community Based Services Requirements. All program implementation plans must meet home and community based setting qualities defined in Section 313 of these rules. ()

(BREAK IN CONTINUITY OF SECTIONS)

663. CHILDREN'S HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.

All children's home and community based services must be identified on a plan of service developed by the family-

centered planning team, ~~including the plan developer~~, and must be recommended by a physician or other practitioner of the healing arts. The following services are reimbursable when provided in accordance with these rules:

~~(7-1-11)~~ ()

01. Respite. Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver. Respite is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Respite may be provided in the participant's home, the private home of the respite provider, a DDA, or in the community. Payment for respite services are not made for room and board. (7-1-11)

- a. Respite must only be offered to participants living with an unpaid caregiver who requires relief. (7-1-11)
- b. Respite cannot exceed fourteen (14) consecutive days. (7-1-11)
- c. Respite must not be provided at the same time other Medicaid services are being provided. (7-1-11)
- d. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. (7-1-11)
- e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others, and must be documented in the participant's record. (7-1-11)
- f. When respite is provided as group respite, the following applies: (7-1-11)
 - i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every six (6) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly. (7-1-11)
 - ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every three (3) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff-to-participant ratio must be adjusted accordingly. (7-1-11)
- g. Respite cannot be provided as group- or center-based respite when delivered by an independent respite provider. (7-1-11)
- h. For Act Early waiver participants, the cost of respite services cannot exceed ten (10) percent of the child's individualized budget amount to ensure the child receives the recommended amount of intervention based on evidence-based research. (7-1-11)

02. Habilitative Supports. Habilitative Supports provides assistance to a participant with a disability by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Habilitative Supports must: (7-1-11)

- a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; (7-1-11)
- b. Ensure the participant is involved in age-appropriate activities and is engaging with typical peers according to the ability of the participant; and (7-1-11)
- c. Have a minimum of one (1) qualified staff providing direct services to every three (3) participants

when provided as group habilitative supports. As the number and severity of the participants with functional impairments increases, the staff participant ratio shall be adjusted accordingly. (7-1-11)

03. Family Education. Family education is professional assistance to families to help them better meet the needs of the participant. It offers education to the parent or legal guardian that is specific to the individual needs of the family and child as identified on the plan of service. Family education is delivered to families to provide an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to their child's diagnoses. (7-1-11)

a. Family education may also provide assistance to the parent or legal guardian in educating other unpaid caregivers regarding the needs of the participant. (7-1-11)

b. The family education providers must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

c. Family education may be provided in a group setting not to exceed five (5) participants' families. (7-1-11)

04. Family-Directed Community Supports. Families of participants eligible for the children's home and community based state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 663.01 through 663.03 of this rule when the participant lives at home with his parent or legal guardian. The requirements for this option are outlined in IDAPA 16.03.13 "Consumer-Directed Services." (7-1-11)

05. Limitations. (7-1-11)

a. HCBS state plan option services are limited by the participant's individualized budget amount. (7-1-11)

b. For the children's HCBS state plan option services listed in Subsections 663.01, 663.02, and 663.04 of this rule, the following are excluded for Medicaid payment: (7-1-11)

i. Vocational services; and (7-1-11)

ii. Educational services. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

680. CHILDREN'S WAIVER SERVICES.

01. Purpose of and Eligibility for Waiver Services. Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children to prevent unnecessary institutional placement, provide for the greatest degree autonomy and of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. (7-1-13)()

02. Waiver Services Provided by a DDA or the Infant Toddler Program. Services provided by a developmental disabilities agency or the Infant Toddler Program to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and

reporting requirements.

(7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

683. CHILDREN'S WAIVER SERVICES: COVERAGE AND LIMITATIONS.

All children's DD waiver services must be identified on a plan of service developed by the family-centered planning team, ~~including the plan developer~~, and must be recommended by a physician or other practitioner of the healing arts. In addition to the children's home and community based state plan option services described in Section 663 of these rules, the following services are available for waiver eligible participants and are reimbursable services when provided in accordance with these rules: ~~(7-1-11)~~ ()

01. Family Training. Family training is professional one-on-one (1 on 1) instruction to families to help them better meet the needs of the waiver participant receiving intervention services. (7-1-11)

a. Family training is limited to training in the implementation of intervention techniques as outlined in the plan of service. (7-1-11)

b. Family training must be provided to the participant's parent or legal guardian when the participant is present. (7-1-11)

c. The family training provider must maintain documentation of the training in the participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

d. The parent or legal guardian of the waiver participant is required to participate in family training when the participant is receiving habilitative interventions. The following applies for each waiver program: (7-1-11)

i. For participants enrolled in the Children's DD Waiver, the amount, duration, and frequency of the training must be determined by the family-centered planning team and the parent or legal guardian, and must be listed as a service on the plan of service. (7-1-11)

ii. For participants enrolled in the Act Early Waiver, the parent or legal guardian will be required to be present and actively participate during the intervention service session for at least twenty percent (20%) of the intervention time provided to the child. (7-1-11)

02. Interdisciplinary Training. Interdisciplinary training is professional instruction to the direct service provider. Interdisciplinary training must only be provided during the provision of a support or intervention service. Interdisciplinary training is provided to assist the direct provider to meet the needs of the waiver participant. (7-1-11)

a. Interdisciplinary training includes: (7-1-11)

i. Health and medication monitoring; (7-1-11)

ii. Positioning and transfer; (7-1-11)

iii. Intervention techniques; (7-1-11)

iv. Positive Behavior Support; (7-1-11)

v. Use of equipment; (7-1-11)

b. Interdisciplinary training must only be provided to the direct service provider when the participant is present. (7-1-11)

c. The interdisciplinary training provider must maintain documentation of the training in the

participant's record documenting the provision of activities outlined in the plan of service. (7-1-11)

d. Interdisciplinary training between a habilitative interventionist and a therapeutic consultant is not a reimbursable service. (7-1-11)

e. Interdisciplinary training between employees of the same discipline is not a reimbursable service. (7-1-11)

03. Habilitative Intervention Evaluation. The purpose of the habilitative intervention evaluation is to guide the formation of developmentally-appropriate objectives and intervention strategies related to goals identified through the family-centered planning process. The habilitative interventionist must complete an evaluation prior to the initial provision of habilitative intervention services. The evaluation must include: (7-1-11)

a. Specific skills assessments for deficit areas identified through the eligibility assessment; (7-1-11)

b. Functional behavioral analysis; (7-1-11)

c. Review of all assessments and relevant histories provided by the plan developer; and (7-1-11)

d. Clinical Opinion. Professional summary that interprets and integrates the results of the testing. This summary includes functional, developmentally appropriate recommendations to guide treatment. (7-1-11)

04. Habilitative Intervention. Habilitative intervention services must be consistent, aggressive, and continuous and are provided to improve a child's functional skills and minimize problem behavior. Services include individual or group behavioral interventions and skill development activity. Habilitative intervention must be based upon the well-known and widely regarded principles of evidence-based treatment. Evidence-based treatment (EBT) refers to the use of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems. As "promising practices" meet statistically significant effectiveness, they could be included as approved approaches. (7-1-11)

a. Habilitative intervention must be provided to meet the intervention needs of the participant by developing adaptive skills for all participants, and addressing maladaptive behaviors for participants who exhibit them. (7-1-11)

i. When goals to address maladaptive behavior are identified on the plan of service, the intervention must include the development of replacement behavior rather than merely the elimination or suppression of maladaptive behavior that interferes with the child's overall general development, community, and social participation. (7-1-11)

ii. When goals to address skill development are identified on the plan of service, the intervention must provide for the acquisition of skills that are functional. (7-1-11)

b. Habilitative intervention must be provided in the participant's home or community setting, and in addition may be provided in a center-based setting. (7-1-11)

c. Group intervention may be provided in the community and center. When habilitative intervention is provided as group intervention, the following applies: (7-1-11)

i. There must be a minimum of one (1) qualified staff providing direct services for every three (3) participants. As the number and severity of the participants with functional impairments or behavioral issues increases, the staff participant ratio must be adjusted accordingly. (7-1-11)

ii. When group intervention is community-based, the child must be integrated in the community in a natural setting with typically developing peers. (7-1-11)

iii. Group intervention must be directly related to meeting the needs of the child, and be identified as an objective in accordance with a plan of service goal. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation provides a higher level of expertise and experience to support participants who exhibit severe aggression, self-injury, and other dangerous behaviors. Therapeutic consultation is provided when a participant receiving habilitative intervention has been assessed as requiring a more advanced level of training and assistance based on the participant's complex needs. A participant requires therapeutic consultation when interventions are not demonstrating outcomes and it is anticipated that a crisis event may occur without the consultation service. (7-1-11)

- a.** The therapeutic consultant assists the habilitative interventionist by: (7-1-11)
 - i.** Performing advanced assessments as necessary; (7-1-11)
 - ii.** Developing and overseeing the implementation of a positive behavior support plan; (7-1-11)
 - iii.** Monitoring the progress and coordinating the implementation of the positive behavioral support plan across environments; and (7-1-11)
 - iv.** Providing consultation to other service providers and families. (7-1-11)
- b.** Telehealth resources may be used by a therapeutic consultant to provide consultation as appropriate and necessary. (7-1-11)
- c.** Therapeutic consultation providers are subject to the following limitations: (7-1-11)
 - i.** Therapeutic consultation cannot be provided as a direct intervention service. (7-1-11)
 - ii.** Participants must be receiving habilitative intervention services prior to accessing therapeutic consultation, with the exception of crisis situations. (7-1-11)
 - iii.** Therapeutic consultation is limited to eighteen (18) hours per year per participant. (7-1-11)
 - iv.** Therapeutic consultation must be prior authorized by the Department. (7-1-11)

06. Crisis Intervention. Crisis intervention services provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience a psychological, behavioral, or emotional crisis. The need for crisis intervention must meet the definition of crisis in Section 681 of these rules. This service may provide training and staff development related to the needs of a participant, and also provides emergency back-up involving the direct support of the participant in crisis. Children's crisis intervention services: (7-1-11)

- a.** Are provided in the home and community. (7-1-11)
- b.** Are provided on a short-term basis typically not to exceed thirty (30) days. (7-1-11)
- c.** Cannot exceed fourteen (14) days of out-of-home placement. (7-1-11)
- d.** Must be prior authorized by the Department. (7-1-11)
 - i.** Authorization for crisis intervention may be requested retroactively as a result of a crisis, defined in Section 681 of these rules, when no other means of support is available to the participant. In retroactive authorizations, the crisis intervention provider must submit a request for crisis intervention to the Department within seventy-two (72) hours of providing the service. (7-1-11)
 - ii.** If staying in the home endangers the health and safety of the participant, the family, or both, the provider may request short-term out of home placement for the participant. Out of home placement must be prior authorized by the Department. (7-1-11)
- e.** Must use positive behavior interventions prior to and in conjunction with the implementation of

any restrictive intervention. (7-1-11)

f. Telehealth resources may be used by a crisis interventionist to provide consultation in a crisis situation. (7-1-11)

07. Family-Directed Community Supports. Families of participants eligible for the children's DD waiver may choose to direct their individualized budget rather than receive the traditional services described in Subsections 683.01 through 683.06 of this rule when the participant lives at home with the parent or legal guardian. The requirements for selecting and participating in this option are outlined in IDAPA 16.03.13 "Consumer Directed Services." Act Early Waiver participants do not have the option to choose the family-directed services path. The Act Early Waiver is intended to be a more structured program that requires increased involvement from families, and ensures children receive an intense amount of services based on evidence-based research. (7-1-11)

08. Service limitations. Children's waiver services are subject to the following limitations: (7-1-11)

a. Place of Service Delivery. Waiver services may be provided in the participant's personal residence, community, or DDA. The following living situations are specifically excluded as a place of service for waiver services: (7-1-11)

i. Licensed skilled or intermediate care facilities, certified nursing facility (NF) or hospital; and (7-1-11)

ii. Licensed Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID); and (7-1-11)

iii. Residential Care or Assisted Living Facility; (7-1-11)

iv. Additional limitations to specific services are listed under that service definition. (7-1-11)

b. According to 42 CFR 440.180, Medicaid Waiver services cannot be used to pay for special education and related services that are included in a child's Individual Educational Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA), that are otherwise available through a local educational agency. (7-1-11)

c. Children's waiver services are limited by the participant's individualized budget amount, excluding crisis intervention. (7-1-11)

d. For the children's waiver services listed in Subsections 683.01 through 683.07 of these rules, the following are excluded for Medicaid payment: (7-1-11)

i. Vocational services; (7-1-11)

ii. Educational services; and (7-1-11)

iii. Recreational services. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: (4-4-13)

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to his community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

02. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home or to provide a clean, sanitary, and safe environment. (4-4-13)

a. Intermittent Assistance may include the following: (4-4-13)

i. Yard maintenance; (4-4-13)

ii. Minor home repair; (4-4-13)

iii. Heavy housework; (4-4-13)

iv. Sidewalk maintenance; and (4-4-13)

v. Trash removal to assist the participant to remain in the home. (4-4-13)

b. Chore activities may include the following: (4-4-13)

- i. Washing windows; (4-4-13)
- ii. Moving heavy furniture; (4-4-13)
- iii. Shoveling snow to provide safe access inside and outside the home; (4-4-13)
- iv. Chopping wood when wood is the participant's primary source of heat; and (4-4-13)
- v. Tacking down loose rugs and flooring. (4-4-13)

c. These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them, or is responsible for their provision. (4-4-13)

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (4-4-13)

03. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, the private home of the respite provider, the community, a developmental disabilities agency, or an adult day health facility. (4-4-13)

04. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (4-4-13)

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. (4-4-13)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that are not directly related to a waiver participant's supported employment program. (4-4-13)

05. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. (4-4-13)

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (4-4-13)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (4-4-13)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: (4-4-13)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (4-4-13)

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. (4-4-13)

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (4-4-13)

07. Specialized Medical Equipment and Supplies. (4-4-13)

a. Specialized medical equipment and supplies include: (4-4-13)

i. Devices, controls, or appliances that enable a participant to increase his abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which he lives; and (4-4-13)

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (4-4-13)

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. (4-4-13)

08. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: (4-4-13)

a. Rent or own a home, or live with unpaid caregivers; (4-4-13)

b. Are alone for significant parts of the day; (4-4-13)

c. Have no caregiver for extended periods of time; and (4-4-13)

d. Would otherwise require extensive, routine supervision. (4-4-13)

09. Home Delivered Meals. Home delivered meals are meals that are delivered to a participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: (4-4-13)

a. Rents or owns a home; (4-4-13)

b. Is alone for significant parts of the day; (4-4-13)

c. Has no caregiver for extended periods of time; and (4-4-13)

d. Is unable to prepare a meal without assistance. (4-4-13)

10. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or

licensed practical nurse, under the supervision of a registered nurse licensed to practice in Idaho. (4-4-13)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. Adult day health cannot exceed thirty (30) hours per week, either alone or in combination with developmental therapy and occupational therapy. (4-4-13)

13. Self-Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in home and community settings as described in Section 312 of these rules. Approved places of services include the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: ~~(3-19-07)~~ ()

- a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)
- b. Licensed Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID); and (3-19-07)
- c. Residential Care or Assisted Living Facility. (3-19-07)
- d. Additional limitations to specific services are listed under that service definition. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

723. TARGETED SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.

An individual is eligible to receive targeted service coordination if he meets the following requirements in Subsection 723.01 through 723.03 of this rule. ~~(5-8-09)~~ ()

- 01. Age.** An adult eighteen (18) years of age or older. (3-29-10)
- 02. Diagnosis.** Is diagnosed with a developmental disability, defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, that:
 - a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (5-8-09)
 - b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (5-8-09)

03. Need Assistance. Requires and chooses assistance to access services and supports necessary to maintain his independence in the community. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.

Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. (3-20-14)

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (5-8-09)

- a. Taking a participant's history; (5-8-09)
- b. Identifying the participant's needs and completing related documentation; and (5-8-09)
- c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (5-8-09)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant. The plan must be updated at least annually and as needed to meet the needs of the participant. (3-20-14)

03. Referral and Related Activities. Activities that help link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. (3-20-14)

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether the following conditions are met: (5-8-09)

- a. Services are being provided according to the participant's plan; (5-8-09)
- b. Services in the plan are adequate; and (5-8-09)
- c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. (5-8-09)

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (5-8-09)

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (5-8-09)

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section ~~507~~ **646** through ~~515~~ **648** of these rules. ~~(5-8-09)~~ **()**

c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service.

(5-8-09)

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services.

(5-8-09)

07. Exclusions. Service coordination does not include activities that are: (5-8-09)

a. An integral component of another covered Medicaid service; (5-8-09)

b. Integral to the administration of foster care programs; (5-8-09)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (3-20-14)

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month. (3-20-14)

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours per year. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

731. SERVICE COORDINATION: PLAN DEVELOPMENT -- WRITTEN PLAN.

The service coordination plan is developed using information collected through the assessment of the participant's service coordination needs. The plan must specify the goals and actions to address the service coordination needs of the participant identified in the assessment process. The plan must include goals developed using the person-centered planning process. (5-8-09)

01. Plan Implementation. The plan must identify activities required to respond to the assessed needs of the participant. (5-8-09)

02. Plan Content. Plans must include the following: (5-8-09)

a. A list of problems and needs identified during the assessment; (5-8-09)

b. Identification of each and any potential risk or substantiation that there are no potential risks. The plan must identify services and actions that will be implemented in case of a participant crisis situation. (5-8-09)

c. Concrete, measurable goals and objectives to be achieved by the participant; (5-8-09)

- d.** Reference to all services and contributions provided by the participant's supports including the actions, if any, taken by the service coordinator to develop the support system; (5-8-09)
 - e.** Documentation of who has been involved in the service planning, including the participant's involvement; (5-8-09)
 - f.** Schedules for service coordination monitoring, progress review, and reassessment; (5-8-09)
 - g.** Documentation of unmet needs and service gaps including goals to address these needs or gaps; (5-8-09)
 - h.** References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery; and (5-8-09)
 - i.** Time frames for achievement of the goals and objectives. (5-8-09)
- 03. Adult Developmental Disability Service Coordination Plan.** The plan for adults with developmental disabilities must comply with and be incorporated into the participant's developmental disability plan of service identified in Section 513 of these rules. ~~(5-8-09)~~ ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.13 - CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

These rule changes align with and implement new requirements in federal regulations that went into effect March 17, 2014, for Idaho's Home and Community Based Services (HCBS) offered through the State Plan, and under the authority of the HCBS 1915(c) waiver and the 1915(i) State Plan Option. The purpose of the regulations is to enhance participants' opportunities to receive services in the most appropriate integrated settings, and to increase their opportunities for choice and access to the benefits of community living.

New rules pertaining to Home and Community Based Services are being added to ensure that participants receiving HCBS services live in and receive services in settings that comply with required qualities of settings, service delivery methods, and person-centered planning processes.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 344 through 353](#).

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

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, Stephanie Perry at (208) 364-1878.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
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THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Monday, October 19, 2015 10:00 a.m. (MDT)	Monday, October 19, 2015 2:00 p.m. (MDT)	Tuesday, October 20, 2015 1:30 p.m. (PDT)
Medicaid Central Office 3232 W. Elder Street Conference Room D -- West/East Boise, ID	Medicaid Region VII Office 150 Shoup Ave., Suite 20 Large Conference Room Idaho Falls, ID	Medicaid Region II Office 1118 "F" Street 2nd Floor Conference Room Coeur d'Alene, ID

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

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

These rule changes are needed to align with and implement new requirements in federal regulations that went into effect March 17, 2014, for Idaho's Home and Community Based Services (HCBS) offered through the State Plan, and under the authority of the HCBS 1915(c) waiver and the 1915(i) State Plan Option. The purpose of the regulations is to enhance participants' opportunities to receive services in the most appropriate integrated settings, and to increase their opportunities for choice and access to the benefits of community living.

New rules pertaining to Home and Community Based Services will be added to ensure that participants receiving HCBS services live in and receive services in settings that comply with required qualities of settings, service delivery methods, and person-centered planning processes.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

This rulemaking has no fiscal impact to the state general fund. This rulemaking is intended to be cost-neutral.

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 June 3, 2015, Idaho Administrative Bulletin, [Vol. 15-6, pages 47-48](#).

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Stephanie Perry at (208) 364-1878.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 31st Day of August, 2015.

LSO Rules Analysis Memo

Italicized red text that is *double underscored* is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0313-1501

010. DEFINITIONS.

01. Circle of Supports. People who encourage and care about the participant and provide unpaid supports. (3-30-07)

02. Community Support Worker. An individual, agency, or vendor selected and paid by the participant to provide community support worker services. (3-30-07)

03. Community Support Worker Services. Community support worker services are those identified supports listed in Section 110 of these rules. (3-30-07)

04. Consumer-Directed Community Supports (CDCS). For the purposes of this chapter, consumer-directed supports include Self-Directed Community Supports (SDCS) and Family-Directed Community Supports (FDCS). (7-1-11)

05. Family-Directed Community Supports (FDCS). A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver and the Children's Home and Community Based Services State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

06. Financial Management Services (FMS). Services provided by a fiscal employer agent that include: (3-29-10)

a. Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets; (3-30-07)

b. Performing payroll services; and (3-30-07)

c. Handling billing and employment related documentation responsibilities. (3-30-07)

07. Fiscal Employer Agent (FEA). An agency that provides financial management services to participants who have chosen the CDCS option. The fiscal employer agent (FEA) is selected by the participant. The duties of the FEA are defined under Section 3504 of the Internal Revenue Code (26 USC 3504). (7-1-11)

08. Goods. Tangible products or merchandise that are authorized on the support and spending plan. (3-30-07)

09. Guiding Principles for the CDCS Option. Consumer-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles: (7-1-11)

a. Freedom for the participant to make choices and plan his own life; (3-30-07)

- b. Authority for the participant to control resources allocated to him to acquire needed supports; (3-30-07)
- c. Opportunity for the participant to choose his own supports; (3-30-07)
- d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (3-30-07)
- e. Shared responsibility between the participant and his community to help the participant become an involved and contributing member of that community. (3-30-07)

10. Home and Community Based Services (HCBS). HCBS are those long-term services and supports that assist eligible participants to remain in their home and community. ()

101. Participant. A person eligible for and enrolled in the Consumer-Directed Services Programs. (7-1-11)

102. Readiness Review. A review conducted by the Department to ensure that each fiscal employer agent is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. (3-29-10)

103. Self-Directed Community Supports (SDCS). A program option for adults eligible for the Adult Developmental Disabilities (DD) Waiver described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

104. Support and Spending Plan. A support and spending plan is a document that functions as a participant's plan of care when the participant is eligible for and has chosen a consumer-directed service option. This document identifies the goods or services, or both, selected by a participant, including those goods, services, and supports available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each of the identified goods and services. The participant uses this document to manage his individualized budget. (3-29-12)

105. Supports. Services provided for a participant, or a person who provides a support service. A support service may be a paid service provided by a community support worker, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. A person who provides a support service for pay is a paid support. A person who provides a volunteer support service is a natural support. (3-30-07)

106. Support Broker. An individual who advocates on behalf of the participant and who is hired by the participant to provide support broker Services. (3-30-07)

107. Support Broker Services. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting. (3-30-07)

108. Traditional Adult DD Waiver Services. A program option for participants eligible for the Adult Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

109. Traditional Children's DD Waiver Services. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

1020. Traditional Children's HCBS State Plan Option Services. A program option for children eligible for the Children's Home and Community-Based Services (HCBS) State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

201. Waiver Services. A collective term that refers to services provided under a Medicaid Waiver program. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

101. ELIGIBILITY.

01. Determination of Medicaid and Home and Community Based Services - DD Requirements. In order to choose the CDCS option, the participant must first be determined Medicaid-eligible and must be determined to meet existing DD waiver programs or HCBS State Plan Option requirements as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-11)

02. Participant Agreement Form. The participant, and his legal representative, if one exists, must agree in writing using a Department-approved form to the following: (3-30-07)

- a. Accept the guiding principles for the CDCS option, as defined in Section 010 of these rules; (7-1-11)
- b. Agree to meet the participant responsibilities outlined in Section 120 of these rules; (3-30-07)
- c. Take responsibility for and accept potential risks, and any resulting consequences, for their support choices; and ~~(3-30-07)~~ ()
- d. Acknowledge and follow the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 310 through 317. ()

03. Legal Representative Agreement. The participant's legal representative, if one exists, must agree in writing to honor the choices of the participant as required by the guiding principles for the CDCS option. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

120. PARTICIPANT RESPONSIBILITIES.

With the assistance of the support broker and the legal representative, if one exists, the participant is responsible for the following: (3-30-07)

01. Guiding Principles. Accepting and honoring the guiding principles for the CDCS option found in Section 010 of these rules. (7-1-11)

02. Person-Centered Planning. ~~Participating in~~ Directing the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. ~~(3-29-12)~~ ()

03. Rates. Negotiating payment rates for all paid community supports he wants to purchase, ensuring rates negotiated for supports and services do not exceed the prevailing market rate, and that are cost-effective when comparing them to reasonable alternatives, and including the details in the employment agreements. (3-29-12)

04. Agreements. Completing and implementing agreements for the fiscal employer agent, the support broker and community support workers and submitting the agreements to the fiscal employer agent. These agreements must be submitted on Department-approved forms. (3-30-07)

05. Agreement Detail. Ensuring that employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement: clearly identifies the qualifications needed to provide the support or service; includes a statement signed by the hired worker that he possesses the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third

party; employees are under the direction and control of the participant; services must be delivered consistent with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 317 through 317; and no employer-related claims will be filed against the Department. ~~(3-30-07)~~ ()

06. Plan. Developing a comprehensive support and spending plan based on the information gathered during the person-centered planning. (3-30-07)

07. Time Sheets and Invoices. Reviewing and verifying that supports being billed were provided and indicating that he approves of the bill by signing the timesheet or invoice. (3-29-10)

08. Quality Assurance and Improvement. Providing feedback to the best of his ability regarding his satisfaction with the supports he receives and the performance of his workers. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

136. SUPPORT BROKER DUTIES AND RESPONSIBILITIES.

01. Support Broker Initial Documentation. Prior to beginning employment for the participant, the support broker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. This packet must include documentation of: (3-30-07)

a. Support broker application approval by the Department; (3-30-07)

b. A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and (3-30-07)

c. A completed employment agreement with the participant that identifies the specific tasks and services that are required of the support broker. The employment agreement must include the negotiated hourly rate for the support broker, and the type, frequency, and duration of services. The negotiated rate must not exceed the maximum hourly rate for support broker services established by the Department. (3-30-07)

02. Required Support Broker Duties. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the support broker must: (3-30-07)

a. ~~Participate in~~ Assist in facilitating the person-centered planning process as directed by the participant and consistent with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 313, 316, and 317; ~~(3-30-07)~~ ()

b. Develop a written support and spending plan with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department; (3-29-12)

c. Assist the participant to monitor and review his budget; (3-30-07)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (3-30-07)

e. Participate with Department quality assurance measures, as requested; (3-30-07)

f. Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization; (3-30-07)

g. Assist the participant, as needed, to meet the participant responsibilities outlined in Section 120 of

these rules and assist the participant, as needed, to protect his own health and safety; (7-1-11)

h. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker. Completion of this form requires that the support broker provide education and counseling to the participant and his circle of support regarding the risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected; and (7-1-11)

i. Assist children enrolled in the Family-Directed Community Supports (FDCS) Option as they transition to adult DD services. (7-1-11)

j. Sign the written support and spending plan as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 317. ()

03. Additional Support Broker Duties. In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant: (3-30-07)

a. Assist the participant to develop and maintain a circle of support; (3-30-07)

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (3-30-07)

c. Assist the participant to negotiate rates for paid community support workers; (3-30-07)

d. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; (3-30-07)

e. Assist the participant to monitor community supports; (3-30-07)

f. Assist the participant to resolve employment-related problems; ~~and~~ ~~(3-30-07)~~ ()

g. Assist the participant to identify and develop community resources to meet specific needs; ~~and~~ ~~(3-30-07)~~ ()

h. Assist the participant in distributing the support and spending plan to community support workers or vendors as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 317. ()

04. Termination of Support Broker Services. If a support broker decides to end services with a participant, he must give the participant at least thirty (30) days' written notice prior to terminating services. The support broker must assist the participant to identify a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The transition plan must include an updated support and spending plan that reflects current supports being received, details about the existing community support workers, and unmet needs. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

160. SUPPORT AND SPENDING PLAN DEVELOPMENT.

01. Support and Spending Plan Requirements. The participant, with the help of his support broker, must develop a comprehensive support and spending plan based on the information gathered during the person-centered planning. The support and spending plan is not valid until authorized by the Department and must include the following: (3-30-07)

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community. (3-30-07)

b. Paid or non-paid consumer-directed community supports that focus on the participant's wants, needs, and goals in the following areas: (7-1-11)

- i. Personal health and safety including quality of life preferences; (3-30-07)
- ii. Securing and maintaining employment; (3-30-07)
- iii. Establishing and maintaining relationships with family, friends and others to build the participant's circle of supports; (3-30-07)
- iv. Learning and practicing ways to recognize and minimize interfering behaviors; and (3-30-07)
- v. Learning new skills or improving existing ones to accomplish set goals. (3-30-07)

c. Support needs such as: (3-30-07)

- i. Medical care and medicine; (3-30-07)
- ii. Skilled care including therapies or nursing needs; (3-30-07)
- iii. Community involvement; (3-30-07)
- iv. Preferred living arrangements including possible roommate(s); and (3-30-07)
- v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. (3-30-07)

d. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; (3-30-07)

e. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; ~~and~~ ~~(3-30-07)~~ ()

f. The budgeted amounts planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The fiscal employer agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment; ~~and~~ ~~(3-30-07)~~ ()

g. Additional HCBS person-centered plan requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 313, 316, and 317. ()

02. Support and Spending Plan Limitations. Support and spending plan limitations include: (3-30-07)

a. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and consumer-directed services at the same time, the participant, the support broker, and the Department must all work together to assure that there is no interruption of required services when moving between traditional services and the CDCS option; (7-1-11)

b. Paid community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services. This limitation does not preclude a participant who has selected the consumer-directed option from choosing to live with recipients of traditional Medicaid services; (7-1-11)

c. All paid community supports must fit into one (1) or more types of community supports described in Section 110 of these rules. The support and spending plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; (3-29-12)

d. Support and spending plans that exceed the approved budget amount will not be authorized; and (3-30-07)

e. Time sheets or invoices that are submitted to the fiscal employer agent for payment that exceed the authorized support and spending plan amount will not be paid by the fiscal employer agent. (3-30-07)

161. -- 169. (RESERVED)

170. PERSON-CENTERED PLANNING.

01. ~~Participation in~~ **Direction of the Person-Centered Planning Process.** The participant agrees to ~~participate in~~ **direct** the person-centered planning process in order to identify and document his support and service needs, wants, and preferences. (3-30-07)()

02. **Participant Choice.** The participant decides who he wants to participate in the planning sessions in order to ensure the participant's choices are honored and promoted. (3-30-07)

03. **Facilitation of Person-Centered Planning Meetings.** The participant may ~~direct~~ **facilitate** his person-centered planning meetings, or these meetings may be facilitated by the chosen support broker. (3-30-07)()

04. **Focus of Person-Centered Planning.** The person-centered planning should focus on identifying strengths, capacities, preferences, needs, and desired goals of the participant for all life areas. (3-30-07)

05. **Timeframes of Person-Centered Planning.** The person-centered planning should be completed as timely as possible in order to provide the necessary information required to develop the participant's support and spending plan. Time limitations are not currently mandated in order to allow for extensive, comprehensive planning and thoughtful support and spending plan development. (3-30-07)

06. **HCBS Person-Centered Planning Requirements.** The person-centered planning process must meet all HCBS requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 316. ()

(BREAK IN CONTINUITY OF SECTIONS)

200. QUALITY ASSURANCE.

The Department will implement quality assurance processes to assure: access to consumer-directed services, participant direction of plans and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. (7-1-11)

01. **Participant Experience Survey (PES).** Each participant will have the opportunity to provide feedback to the Department about his satisfaction with consumer-directed services utilizing the PES. (7-1-11)

02. **Participant Experience Outcomes.** Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: (3-30-07)

a. Access to care; (3-30-07)

b. Choice and control; (3-30-07)

- c. Respect and dignity; (3-30-07)
- d. Community integration; and (3-30-07)
- e. Inclusion. (3-30-07)

03. Fiscal Employer Agent Quality Assurance Activities. The fiscal employer agent must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, maintaining a list of criminal history check waivers, and timely reporting of accounting and satisfaction data. (3-30-07)

04. Community Support Workers and Support Brokers Quality Assurance Activities. Community support workers and support brokers must participate and comply with quality assurance activities identified by the Department including performance evaluations, satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records. (3-30-07)

05. Participant Choice of Paid Community Support Worker. Paid community support workers must be selected by the participant, or his chosen representative, and must meet the qualifications identified in Section 150 of this rule. (3-30-07)

06. Complaint Reporting and Tracking Process. The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. (3-30-07)

07. Quality Oversight Committee. A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. (3-30-07)

08. Quarterly Quality Assurance Reviews. On a quarterly basis, the Department will perform an enhanced review of services for those participants who have waived the criminal history check requirement for a community support worker or who have their legal guardian providing paid services. These reviews will assess ongoing participant health and safety and compliance with the approved support and spending plan. (3-30-07)

09. Home and Community Based Service Specific Reviews. The Department will implement quality assurance and improvement activities to ensure compliance with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 310 through 317. ()

(BREAK IN CONTINUITY OF SECTIONS)

301. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: CONSUMER-DIRECTED COMMUNITY SUPPORTS.

01. Federal Tax ID Requirement. The fiscal employer agent must obtain a separate Federal Employer Identification Number (FEIN) specifically to file tax forms and to make tax payments on behalf of program participants under Section 3504 of the Internal Revenue Code (26 USC 3504). In addition, the provider must: (3-29-10)

- a. Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for FEIN in the participant's file. (3-29-10)
- b. Retire participant's FEIN when the participant is no longer an employer under consumer-directed community supports (CDCS). (7-1-11)

02. Requirement to Report Irregular Activities or Practices. The provider must report to the Department any facts regarding irregular activities or practices that may conflict with federal or state rules and

regulations; (3-29-10)

03. Procedures Restricting FMS to Adult and Children's DD Waiver and Children's HCBS State Plan Option Participants. The provider must not act as a fiscal employer agent and provide fiscal management services to a DD waiver or Children's HCBS State Plan Option participant for whom it also provides any other services funded by the Department. (7-1-11)

04. Policies and Procedures. The provider must maintain a current manual containing comprehensive policies and procedures. The provider must submit the manual and any updates to the Department for approval. (3-29-10)

05. Key Contact Person. The provider must provide a key contact person and at least (2) two other people for backup who are responsible for answering calls and responding to e-mails from Department staff and ensure these individuals respond to the Department within one (1) business day. (3-29-10)

06. Face-to-Face Transitional Participant Enrollment. The provider must conduct face-to-face transitional participant enrollment sessions in group settings or with individual participants in their homes or other designated locations. The provider must work with the regional Department staff to coordinate and conduct enrollment sessions. (3-29-10)

07. SFTP Site. The provider must provide an SFTP site for the Department to access. The site must have the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. The site must be user name and password protected. The provider must have the site accessible to the Department upon commencement of the readiness review. (3-29-10)

08. Required IRS Forms. The provider must prepare, submit, and revoke the following IRS forms in accordance with IRS requirements and must maintain relevant documentation in each participant's file including: (3-29-10)

- a. IRS Form 2678; (3-29-10)
- b. IRS Approval Letter; (3-29-10)
- c. IRS Form 2678 revocation process; (3-29-10)
- d. Initial IRS Form 2848; and (3-29-10)
- e. Renewal IRS Form 2848. (3-29-10)

09. Requirement to Obtain Power of Attorney. The provider must obtain an Idaho State Tax Commission Power of Attorney (Form TC00110) from each participant it represents and must maintain the relevant documentation in each participant's file. (3-29-10)

10. Requirement to Revoke Power of Attorney. The provider must revoke the Idaho State Tax Commission Power of Attorney (Form TC00110) when the provider no longer represents the participant and must maintain the relevant documentation in the participant's file. (3-29-10)

11. Home and Community Based Person-Centered Service Plan Requirements. The provider must sign the written support and spending plan as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 317. ()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.16 - PREMIUM ASSISTANCE

DOCKET NO. 16-0316-1501 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This action is authorized pursuant to Sections 56-202, 56-241, and 56-242, Idaho Code.

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

There are no changes to the repeal of the Premium Assistance chapter in the pending rule and it is being adopted as originally proposed. The notice of repeal for the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, page 101](#).

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

There is no anticipated fiscal impact to the state general fund or to any other funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not feasible since the rulemaking is non-negotiable. These rules are to comply with state law and federal regulations.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Cindy Brock at (208) 364-1983.

DATED this 2nd Day of October, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This action is authorized pursuant to Sections 56-202, 56-241, and 56-242, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 19, 2015.

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

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

The Premium Assistance chapter of rules is being repealed in its entirety. State law removed reference to the Children's Access Card Program, and the federally funded waiver known as "premium assistance" was discontinued, making these rules obsolete.

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

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

There is no anticipated fiscal impact to the state general fund or to any other funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not feasible since the rulemaking is non-negotiable. These rules are to comply with state law and federal regulations.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at (208) 364-1983.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0316-1501

IDAPA 16.03.16 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.02 - IDAHO TELECOMMUNICATION SERVICE ASSISTANCE PROGRAM RULES

DOCKET NO. 16-0402-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-901, Idaho Code, and 47 CFR Sections 54.101 through 54.422.

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

There are no changes being made in the pending rule aligning this chapter with state policies and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 354 through 356](#).

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

There is no anticipated fiscal impact to the state general fund or to any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Kristin Matthews at (208) 334-5553.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-901, Idaho Code, and 47 CFR Sections 54.101 through 54.422.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

This rule change is needed to align these rules with the state policies and the Department's current business practices for contracting with qualified entities to provide services as needed for the Telecommunication Service Assistance Program in Idaho. These rules remove outdated information, and update definitions to reflect current practices.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

There is no anticipated fiscal impact to the state general fund as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rulemaking is simple in nature and aligns rules with federal limits.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sara Herring at (208) 334-5752.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 28th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0402-1501

010. DEFINITIONS.

01. Assistance Rate Discount. A monthly discount to eligible “lifeline” subscribers for basic local service under the Idaho Telecommunication Service Assistance Program (ITSAP) authorized in Sections 56-901 through 56-904, and 62-610, Idaho Code. (4-4-13)

~~**02. Community Action Agency.** A private, non-profit organization serving the low-income population in specified counties of the state which meet the requirements to be designated as a community action agency according to the Community Services Block Grant Act, and has entered into a contract with the Idaho Department of Health and Welfare for the provision of ITSAP services. (4-4-13)~~

~~**032. Department.** The Idaho Department of Health and Welfare or its designee. (3-5-91)()~~

~~**043. Eligibility Application.** The current Participant Assessment Application form or the Application~~

for Assistance (AFA) form. (7-1-99)

054. Eligible Basic Local Service. A single telecommunication service at the eligible subscriber household. (3-20-14)

065. Federal Poverty Guidelines (FPG). The poverty guidelines issued annually by the Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services at <http://aspe.hhs.gov/poverty>. (4-4-13)

076. Head of Household. The adult member of a household responsible for payment of at least fifty percent (50%) of the cost of the basic local service. (4-4-13)

087. Household. A household is either an individual living alone or a group of individuals who are living together at the same address as one economic unit. A household may include related and unrelated persons. An "economic unit" consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen (18) years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him, both people shall be considered part of the same household. Children under the age of eighteen (18) living with their parents or guardians are considered to be part of the same household as their parents or guardians. (4-4-13)

098. Income. Income is the gross amount of money actually received in the recipients household from all sources. (4-4-13)

109. ITSAP. Idaho Telecommunication Service Assistance Program. (4-4-13)

110. Lifeline. ITSAP component that provides a monthly discount rate to eligible subscribers on their basic local service costs. (4-4-13)

121. Provider. The eligible telecommunication carrier providing basic local service to Idaho residents. (4-4-13)

132. Recipient. A person who is determined eligible for ITSAP. (4-4-13)

143. Subscriber. A person applying for basic local service or, in whose name the basic local service is listed. The subscriber does not need to be the head of the household. (4-4-13)

011. -- 099. (RESERVED)

100. ASSISTANCE ELIGIBILITY REQUIREMENTS.

01. Head of Household. A recipient must be the head of the household. (4-4-13)

02. Application. A person must complete an application ~~with the Department or Community Action Agency~~ on behalf of ~~his~~ the household, listing all members. The application may be completed by a person other than the head of the household. (7-1-99)()

03. Income Limit. The household's gross income must be at or below one hundred and thirty-five percent (135%) of the Federal Poverty Guideline (FPG). Households receiving any type of state or federal assistance with income limits at or below one hundred and thirty-five percent (135%) of the FPG are income eligible for ITSAP. (4-4-13)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.13 - RULES GOVERNING THE EMERGENCY FOOD ASSISTANCE PROGRAM

DOCKET NO. 16-0413-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code, and Sections 201 through 212 of Public Law 98-8 as amended.

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

There are no changes being made in the pending rule aligning this chapter with state policies and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 357 through 359](#).

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

There is no anticipated fiscal impact to the state general fund or to any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Kristin Matthews at (208) 334-5553.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code, and Sections 201 through 212 of Public Law 98-8 as amended.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

This rule change is needed to align these rules with the state policies and the Department's current business practices for contracting with qualified entities to provide services as needed for the Emergency Food Assistance Program in Idaho. These rules remove outdated information and update definitions and references to reflect current practices.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

There is no anticipated fiscal impact to the state general fund or any other funds as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rulemaking is simple in nature and aligns rules with federal limits.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sara Herring at (208) 334-5752.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 28th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0413-1501

004. DEFINITIONS.

For the purpose of these rules the following terms are used, as defined herein: (9-1-85)

01. Allocation. The state of Idaho's share of the Emergency Food Assistance Program monies as determined by the funding formula contained in 7 CFR 250, 251, the Emergency Food Assistance Program. (10-1-94)

02. Applicant Household. A household which has made application to receive USDA surplus commodities and has not been determined an eligible recipient. (4-5-00)

03. Application. The action by which a household completes in writing an application form to be considered for receipt of USDA surplus commodities. (10-1-94)

04. Commodities. Surplus and purchased food items made available by the Commodity Credit

Corporation for distribution to low-income households. (10-1-94)

05. Community Action Agency. A private non-profit organization serving the low-income population in specified counties of the state ~~with which the Department has entered into a contract for the provision of services for purposes of TEFAP~~ which has been designated as an eligible entity according to the Community Services Block Grant Act 42 USC 9901 et seq. (4-5-00)()

06. Community Action Program. A program of services offered by an office or offices for the Community Action Agency. (9-1-85)

07. Department. The Idaho Department of Health and Welfare or its designee. (12-31-91)()

08. Eligible Entities. Agencies eligible to administer the TEFAP at the local level who have entered into a contract with the Department and include the following: (4-5-00)

- a.** Community Action Agencies; (9-1-85)
- b.** Community Action Programs operating programs funded under the Community Services Block Grant Act; (9-1-85)
- c.** Other incorporated non-profit agencies; (4-5-00)
- d.** Government agencies; or (4-5-00)
- e.** Disaster Relief Programs. (4-5-00)

09. Eligible Household. A household which meets the standard of eligibility set forth in these rules. (9-1-85)

10. Emergency Feeding Organization (EFO). Organizations who have entered into an agreement with an eligible entity for the purposes of distributing USDA Commodities. (4-5-00)

11. Household. A household is one (1) of the following: (4-5-00)

- a.** An individual living alone; or (9-1-85)
- b.** A group of individuals living together in common living quarters who share the cost and preparation of meals. (9-1-85)

12. Income. Total household income. (4-5-00)

13. Earnings from Self-Employment. Earnings from self-employment include net income plus any depreciation and depletion previously deducted as expenses. This includes farm or business income. (4-5-00)

14. Poverty Guideline. The official poverty guideline established by the Secretary of Health and Human Services in accordance with the Omnibus Reconciliation Act, Section 673(2). (10-1-94)

15. Program Year. October 1st through September 30th. (2-11-88)

16. Proof of Income. Written self-declaration of total household income. (4-5-00)

17. Service Area. The state of Idaho is divided into the following seven (7) service areas for the purpose of fund distribution: (9-1-85)

- a.** Region I -- Kootenai County, Shoshone County, Benewah County, Bonner County, and Boundary County. (9-1-85)

- b.** Region II -- Nez Perce County, Clearwater County, Idaho County, Latah County, and Lewis County. (9-1-85)
- c.** Region III -- Canyon County, Adams County, Gem County, Payette County, Washington County, Valley County, and Boise County. (9-1-85)
- d.** Region IV -- Ada County, Elmore County, and Owyhee County. (9-1-85)
- e.** Region V -- Twin Falls County, Blaine County, Cassia County, Gooding County, Camas County, Jerome County, Lincoln County, and Minidoka County. (9-1-85)
- f.** Region VI -- Bannock County, Bear Lake County, Bingham County, Caribou County, Franklin County, Oneida County, and Power County. (9-1-85)
- g.** Region VII -- Bonneville County, Butte County, Clark County, Fremont County, Jefferson County, Lemhi County, Madison County, and Teton County. (9-1-85)
- 18. State Distribution Rate.** The amount of commodities an eligible household can receive based on the number of persons in their household. (9-1-85)

(BREAK IN CONTINUITY OF SECTIONS)

006. CASE RECORD.

The ~~CAA~~ Department will maintain accurate and complete records on a household's participation. This record must be kept ~~in a permanent CAA file~~ for a period of at least three (3) years. (4-5-00)()

007. APPLICANT RIGHTS.

Households applying for TEFAP surplus commodities have certain rights. These rights include, but are not limited to, the following: (9-1-85)

01. Right to Apply. Any household wishing to apply must be given the opportunity to apply for TEFAP surplus commodities. All applications must be in writing on forms prescribed by DHW. (9-1-85)

02. Civil Rights. The rights of applicant households must be respected under the U.S. and Idaho Constitutions, the Social Security Act, Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, and all other relevant provisions of federal and state law, including the avoidance of practices which violate a person's privacy or subject him to harassment. (9-1-85)()

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.14 - RULES GOVERNING THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

DOCKET NO. 16-0414-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to the Low-Income Home Energy Assistance Act of 1981, 42 U.S.C Sections 8621 to 8629, and by provisions of Section 56-202 Idaho Code.

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

There are no changes being made in the pending rule aligning this chapter with state policies and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 360 through 363](#).

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

There is no anticipated fiscal impact to the state general fund or to any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Kristin Matthews at (208) 334-5553.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to the Low-Income Home Energy Assistance Act of 1981, 42 U.S.C Sections 8621 to 8629, and by provisions of Section 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 October 21, 2015.

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

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

This rule change is needed to align these rules with the state policies and the Department's current business practices for contracting with qualified entities to provide services as needed for the Low Income Home Energy Assistance Program in Idaho. These rules remove outdated information, update definitions and references to reflect current practices.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

There is no anticipated fiscal impact to the state general fund or any other funds as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rulemaking is simple in nature and aligns rules with federal limits.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sara Herring at (208) 334-5752.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 28th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0414-1501

004. INCORPORATION BY REFERENCE.

~~The following document is incorporated by reference in this chapter of rule: Low Income Home Energy Assistance Program (LIHEAP) Intake Manual, 2006. The manual is available on the Internet at <http://www.healthandwelfare.idaho.gov/>. The manual is also available at the mailing address listed in Section 005 of this rule, and at Community Action Agencies~~ **No documents are incorporated by reference into this chapter of rules.** (3-30-07)()

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

~~Definitions applicable to~~ **For purposes of** this chapter of rules, **the following terms apply.** (3-30-07)()

~~01. Community Action Agency. A private non-profit organization serving the low income population in specified counties of the state with which the Department has entered into a contract for the provision of services for purposes of LIHEAP.~~ (3-30-07)

021. Crisis Assistance. Energy assistance provided to an eligible participant household to reduce or eliminate an energy related health threatening situation to the household. (3-30-07)

032. Department. The Department of Health and Welfare or its designee. (3-30-07)

043. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the U. S. Department of Health and Human Services (HHS). The federal poverty guidelines are available on the U.S. Health and Human Services website at: <http://aspe.hhs.gov/poverty/>. (3-29-12)

054. Fraud. Recipient fraud is indicated where there appears to be a deliberate attempt to conceal or misrepresent pertinent information which could affect eligibility or grant amounts. (7-1-99)

065. Head of Participant Household. The person designated by the household members to receive energy assistance benefit in behalf of the household and in whose favor the energy assistance warrant is written. (7-1-99)

076. Income. Income is the gross amount of moneys actually received in the participant household from all sources. (4-5-00)

087. Intake Manual. Manual used by ~~community action agencies~~ the Department for procedural policy and benefit calculation factors, ~~which is published annually by the Department.~~ (3-30-07)()

098. Participant. An individual or group of individuals who has made application for the Low Income Home Energy Assistance Program from the state of Idaho. (3-30-07)

109. Participant Household. A participant household is one (1) of the following: (3-30-07)

a. An individual who lives alone; or (3-30-07)

b. A group of individuals who are living together as one (1) economic unit where residential energy is customarily purchased in common or they make undesignated payments for energy in the form of rent. (3-30-07)

110. Primary Fuel. The type of fuel declared by the participant household to be the major source of their home heating. (7-1-99)

121. Undocumented Resident. Individuals who enter the United States illegally and who have not obtained legal resident status. (3-30-07)

132. Vendor. A utility company or other provider of fuel utilized for home heating. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

102. PARTICIPANT RIGHTS.

The participant has rights protected by federal and state laws and Department rules. The Department ~~or their designee~~ must inform the participant of their rights during the application process and eligibility determination, as follows: (7-1-99)()

01. Right to Apply. Any participant household wishing to apply must be given the opportunity, without delay, to apply for LIHEAP benefits. All participants must apply in writing. (7-1-99)

02. Right to a Hearing. Rules governing hearing rights are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-01)

03. Civil Rights. The rights of participant households must be respected under the U.S. and Idaho Constitutions, the Social Security Act, Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, and all other relevant provisions of federal and state law, including the avoidance of practices which violate a person's privacy or subjection to harassment. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

200. INTAKE PROCESS.

Low-income participants ~~may~~ **must** complete an application for LIHEAP benefits ~~at a CAA and submit the application to the Department.~~ The ~~CAA will submit the~~ participant's household information contained on the application **will be entered into** the Department's on-line computer system for issuance of eligibility notification. (7-1-99)()

201. APPLICATION PROCESS.

A participant must be provided a prompt opportunity to complete an application for assistance. Application forms must contain a statement which clearly explains participant's civil and criminal liability for the truthfulness of the information included on the forms; and their right to a hearing according to Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Cases Proceedings and Declaratory Rulings." (7-1-99)

01. Date of Application. The participant application process begins the date the completed and signed application and all supporting forms are received by the ~~CAA~~ **Department.** (7-1-99)()

02. Participant Representation. A participant household may be assisted by a person or persons of their choice and, when accompanied by such persons, may be represented by them. (7-1-99)

03. Signature. The application must be signed by the participant designated at the head of household, or their designee. (7-1-99)

a. Applications signed by a designee must have a letter of authorization or power of attorney from the participant included in the file. (3-15-02)

b. Employees of the ~~CAA or the~~ Department must not be designated to sign the application. (7-1-99)()

04. Signature by Mark. A signature by mark requires two (2) witnesses. The signatures and addresses of the witnesses must appear on the application, followed by the word "witness." (7-1-99)

05. Assistance with Application. When completing the application forms or obtaining required documentation, each participant must be provided assistance from the ~~CAA~~ **Department**, including the provision for interpreters for participant households with limited or non-English speaking skills. (7-1-99)()

(BREAK IN CONTINUITY OF SECTIONS)

204. BENEFIT DETERMINATION.

Eligible participant households will have their LIHEAP benefit determined as follows: (3-20-04)

01. Actual Consumption Method. The actual consumption method is used if the eligible participant household heats its residence with either natural gas or electricity and has resided in the residence for one (1) year or longer. Household benefit is calculated by multiplying the energy consumption cost by an annual benefit calculation factor. Annual minimum and maximum benefits per household are published each year in the Intake Manual used for LIHEAP. (3-20-04)

02. Average Annual Cost Method. The average annual cost method is used when the eligible

participant household's actual consumption cost is unknown, or it uses a heating source other than electricity or natural gas. Average cost is determined by information provided by energy suppliers throughout the state and is published as the Annual Heating Cost Chart which is available from the Department of Health and Welfare. The average cost is specific to county of residence and the household's heating source. Household benefit is calculated by multiplying the Average Annual Cost by an annual benefit calculation factor. (3-20-04)

03. Annual Benefit Calculation Factor. Annual benefit calculation factors are determined each year based on the amount of federal funding for the upcoming program year. The particular factor used for a household's benefit calculation is determined by the household's energy cost burden (high, medium or low) expressed as a percentage of annualized income. A heating burden of zero percent (0%) to five percent (5%) is low, six percent (6%) to ten percent (10%) is medium, and eleven percent (11%) or greater is high. Benefit calculation methodology and the current benefit calculation factors are published in the Intake Manual used for LIHEAP, available at the Department ~~or on its website, and at community action agencies.~~ (3-30-07)()

04. Adjusting LIHEAP Benefit. Households containing at least one (1) of the following may be eligible for an adjusted benefit. The adjusted benefit amounts and eligibility levels will be published annually in the Intake Manual used for LIHEAP, available at the Department ~~or on its website, and at community action agencies.~~ (3-30-07)()

- a. Child under six (6) years of age. (4-5-00)
- b. Individual with disabilities as declared on the LIHEAP application form. (4-5-00)
- c. Individual sixty (60) years of age or older. (4-5-00)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.04.16 - WEATHERIZATION ASSISTANCE PROGRAM IN IDAHO

DOCKET NO. 16-0416-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code; also to Part A of the Weatherization Assistance for Low-Income Persons, 42 U.S.C. 6861-6872, and the Department of Energy Organization Act, 42 U.S.C. 7101.

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

There are no changes being made in the pending rule aligning this chapter with state policies and it is being adopted as originally proposed. The complete text of the proposed rule published in the October 7, 2015, Idaho Administrative Bulletin, [Vol. 15-10, pages 364 through 368](#).

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

There is no anticipated fiscal impact to the state general fund or to any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Kristin Matthews at (208) 334-5553.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code; also to Part A of the Weatherization Assistance for Low-Income Persons, 42 U.S.C. 6861-6872, and the Department of Energy Organization Act, 42 U.S.C. 7101.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

This rule change is needed to align these rules with the state policies and the Department's current business practices for contracting with qualified entities to provide services as needed for the Weatherization Assistance Program in Idaho. These rules remove outdated information, update definitions and reference to reflect current practices.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

There is no anticipated fiscal impact to the state general fund or any other funds as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rulemaking is simple in nature and aligns rules with federal limits.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sara Herring at (208) 334-5752.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 28th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0416-1501

010. DEFINITIONS AND ABBREVIATIONS.

For purposes of this chapter of rules, the following terms and abbreviations ~~are used as defined~~ apply. (5-8-09) ()

~~01. Community Action Agency (CAA). A private corporation or public agency established according to the Economic Opportunity Act of 1964, 42 USC 2701, et seq., which is authorized to administer funds received from federal, state, local, or private funding entities to assess, design, operate, finance, and oversee anti poverty programs.~~ (5-8-09)

~~021. Contractor.~~ A weatherization project entity at the sub-state level which receives a contract from the Department to carry out activities of this program. (5-8-09)

~~032~~. Cosmetic Items. Items which, when installed, will not reduce energy costs in a cost effective manner, such as finishes, decorative materials, elevation materials, aluminum siding, board and bat, clapboard, brick, shakes, or asphalt siding. (5-8-09)

~~043~~. Department. The Idaho Department of Health and Welfare or its designee. (5-8-09)

~~054~~. DOE. The U.S. Department of Energy. (5-8-09)

~~065~~. Dwelling Unit. A house, including a stationary mobile home, an apartment, a group of rooms or a single room occupied as separate living quarters. (5-8-09)

a. Rental Dwelling Unit. A dwelling unit occupied by a person who pays rent for use of the dwelling unit. (5-8-09)

b. Single-Family Dwelling Unit. A structure containing no more than one (1) dwelling unit. (5-8-09)

~~076~~. Elderly Person. A person who is sixty (60) years of age or older. (5-8-09)

~~087~~. EPA. The U.S. Environmental Protection Agency. (5-8-09)

~~098~~. Family Unit. All persons living together in a dwelling unit. (5-8-09)

~~109~~. Grantee. The Idaho Department of Health and Welfare. (5-8-09)

~~110~~. Household. All persons living together in a dwelling unit. (5-8-09)

~~121~~. Heating or Cooling Sources. A device which raises or lowers the temperature within a dwelling unit that is part of the permanent heating, ventilating and air-conditioning system installed in the dwelling unit. Examples of a heating or cooling system are: furnaces, heat pumps, stoves, boilers, heaters, fireplaces, air-conditioners, fans, or solar devices. (5-8-09)

~~132~~. Low-Income. Income as it relates to family size which is: (5-8-09)

a. Determined using criteria established by the Director of the Office of Management and Budget, unless a higher level has been established by the Secretary and is necessary to carry out the purpose of this part and is consistent with the eligibility criteria established for the weatherization program under Section 222(a)(12) of the Economic Opportunity Act of 1964; (3-29-10)

b. The basis on which cash assistance payments have been paid during the preceding twelve (12) month period under Titles IV and XVI of the Social Security Act, 42 USC 301, or applicable state or local law; or (5-8-09)

c. The basis for eligibility for assistance under the Low Income Home Energy Assistance Act of 1981. (3-29-10)

~~143~~. Mechanical Equipment. A control device or apparatus which is primarily designed to improve the heating or cooling efficiency of a dwelling unit, and which will permanently be affixed to an existing heating or cooling source, such as flue dampers, clock thermostats, filters, and replacements limit switches. (5-8-09)

~~154~~. Occupants. A single family, one (1) person living alone, two (2) or more families living together, or any other group of related or unrelated persons who share living arrangements. (5-8-09)

~~165~~. Persons with Disabilities. Any individual who is: (5-8-09)

a. Handicapped as defined in Section 7(6) of the Rehabilitation Act of 1973; (5-8-09)

b. Under a disability as defined in Section 1614(a)(3)(A) or 223(d)(1) of the Social Security Act or in

Section 102(7) of the Developmental Disabilities Services and Facilities Construction Act; or (5-8-09)

c. Receiving benefits under Chapter 11 or 15 of Title 38, U.S.C. (5-8-09)

~~176~~. **Regional Representative.** A Regional Representative of the U.S. Department of Energy. (5-8-09)

~~187~~. **Secretary.** The Secretary of the U.S. Department of Energy. (5-8-09)

~~198~~. **Separate Living Quarters.** Living quarters in which the occupants do not live and eat with any other persons in the structure and have direct access from the outside of the building or through a common hall or complete kitchen facilities for the exclusive use of the occupants. The occupants may be related or unrelated persons who share living arrangements, and includes shelters for homeless persons. (5-8-09)

~~209~~. **Shelter.** A dwelling unit or units whose principal purpose is to house on a temporary basis individuals who may or may not be related to one another and who are not living in nursing homes, prisons, or similar institutional care facilities. (5-8-09)

~~240~~. **Subgrantee.** An entity managing a weatherization project which receives a grant or contract of funds awarded under this program from the Department ~~or CAA~~. ~~(5-8-09)~~ ()

~~221~~. **Weatherization Project.** A project conducted in a single geographical area which undertakes to weatherize dwelling units which are energy inefficient. (5-8-09)

~~232~~. **Weatherization Materials.** Items used to improve the heating or cooling efficiency of a dwelling unit, such as: (5-8-09)

a. Caulking and weatherstripping of doors and windows; (5-8-09)

b. Furnace efficiency modifications which include replacement burners, furnaces, or boilers or any combination thereof; (5-8-09)

c. Devices for minimizing energy loss through heating system, chimney, or venting devices; (5-8-09)

d. Electrical or mechanical furnace ignition systems which replace standing gas pilot lights; and (5-8-09)

e. Cooling efficiency modifications that include replacement air conditioners, ventilation equipment, screening and window films, and shading devices. (5-8-09)

011. -- 049. (RESERVED)

050. FEDERAL REQUIREMENTS.

01. Record Keeping. Each subgrantee receiving federal financial assistance under the Weatherization Assistance Program must keep records as required by the DOE, which include the following: (5-8-09)

a. Records that fully disclose the amount and disposition by subgrantee of the funds received; (5-8-09)

b. The total cost of a weatherization project; (5-8-09)

c. The total expenditure to implement the weatherization plan for which such assistance was given or used; (5-8-09)

d. The source and amount of funds for such project or program not supplied by DOE and corresponding records; (5-8-09)

- e. Documentation of the average costs incurred in weatherization of individual dwelling units; (5-8-09)
 - f. Documentation of the average size of the dwelling being weatherized; (5-8-09)
 - g. Documentation of the average income of households receiving assistance; and (5-8-09)
 - h. Records and documentation DOE finds necessary for an effective audit and performance evaluation as determined by the DOE Financial Assistance Rule, 10 CFR Part 600, and any requirements of 10 CFR Part 440, Direct Final Rule and EPA Title 40 Part 745.86. (5-8-09)()
- ~~02. Reports. Each subgrantee receiving financial assistance under the Weatherization Assistance Program must provide the Department with:~~ (5-8-09)
- ~~a. A monthly program performance report on Form EIA-29A "Low-Income Weatherization Quarterly Report Supplement," and~~ (5-8-09)
 - ~~b. A monthly financial report on Form EIA-298 "Financial Status Report."~~ (5-8-09)
- ~~03.2. Matching Funds.~~ Financial assistance under the Weatherization Assistance Program will be used to supplement, and not to supplant, local funds, and to the maximum extent practicable as determined by DOE, to increase the amounts of local funds that would be made available in the absence of federal funds provided under the Program. (5-8-09)
- ~~04.3. Program Coordination.~~ To the maximum extent practicable, the use of weatherization assistance must be coordinated with other federal, state, local, or privately funded programs in order to improve energy efficiency and to conserve energy. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

300. WEATHERIZATION MATERIALS STANDARDS AND ENERGY AUDIT PROCEDURES.

01. **Approved Weatherization Materials.** Only weatherization materials which meet or exceed standards prescribed in Appendix A to 10 CFR Part 440 may be purchased. However, unlisted materials may be approved by the state upon application from any ~~CAA~~ subgrantee. Such application must be made to DOE by the state. (5-8-09)()
02. **Cost Effective Materials.** Except for materials to eliminate health and safety hazards allowable under 10 CFR Part 440.18(c)(15), each individual weatherization material and package of weatherization materials installed in an eligible dwelling unit must be cost-effective. (5-8-09)
03. **Energy Audit.** The energy audit procedures must assign priorities among individual weatherization materials in descending order of their cost-effectiveness according to 10 CFR Part 440. (5-8-09)

301. -- 499. (RESERVED)

500. OVERSIGHT, TRAINING, AND TECHNICAL ASSISTANCE.

01. **Audit Frequency.** The Department will ensure that audits by or on the behalf of subgrantees are conducted ~~with reasonable frequency, on a continuing basis, or at scheduled intervals, usually annually, but not less frequently than every two (2) years, in accordance with 10 CFR Part 600, and OMB Circular 110, Attachment F, as applicable~~ according to DOE requirements. (5-8-09)()
02. **Monitoring.** The Department, as grantee for the U.S. Department of Energy Weatherization Assistance Grants, will monitor and evaluate the operation of projects carried out by the subgrantees through on-site

inspections and other means to insure the effective provision of weatherization assistance in a nondiscriminatory manner for dwelling units of low-income residents of the State of Idaho. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.05.01 - USE AND DISCLOSURE OF DEPARTMENT RECORDS

DOCKET NO. 16-0501-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code (Joint rules).

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

The 2015 legislature passed S1077 which clarified that the person with authority to designate disposition of a decedent's remains should be considered a person with a "direct and tangible interest" and thus is entitled to receive an official death certificate. This rule amendment aligns these rules with the amended statute.

Specifically, this rulemaking adds the clarification that any person designated in Section 54-1142(1), Idaho Code, has "a direct and tangible interest" in the death certificate of a decedent in accordance with to Section 39-270(b), Idaho Code.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 5, 2015, Idaho Administrative Bulletin, [Vol. 15-8, pages 102 through 104](#).

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

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

This rulemaking has no fiscal impact to the state general fund or any other funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact James Aydelotte (208) 334-4969.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-242, 39-5403, 56-221, 56-222, 56-1003, and 56-1004, Idaho Code (Joint rules).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 19, 2015.

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

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

The 2015 legislature passed S1077 which clarifies that the person with authority to designate disposition of a decedent's remains should be considered a person with a "direct and tangible interest" and thus is entitled to receive an official death certificate. This proposed rule amendment aligns these rules with the amended statute.

Specifically, this proposed rule adds the clarification that any person designated in Section 54-1142(1), Idaho Code, has "a direct and tangible interest" in the death certificate of a decedent in accordance with to Section 39-270(b), Idaho Code.

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

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

This rulemaking has no fiscal impact to the state general fund or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking was deemed not feasible as this rule change is simple in nature.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact James Aydelotte (208) 334-4969.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 26, 2015.

DATED this 7th Day of July, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0501-1501

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. (3-20-04)

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. (3-20-04)

02. Certificate. A certificate of birth, death, stillbirth, marriage, or divorce, filed pursuant to law, excluding information contained in the statistical section of any record. (3-20-04)

03. Individuals with a Direct and Tangible Interest. Individuals who have a direct and tangible interest in a vital record are: (3-20-04)

a. The registrant and that person's spouse, children, parents, grandparents, grandchildren, siblings, or guardian; (3-20-04)

b. A person who is conducting genealogical research on the person's own family; (3-20-04)

c. Any other person who demonstrates that the record is needed for the determination or protection of that person's property right; (3-20-04)

d. An authorized representative of any of these individuals; (3-20-04)

e. The surviving next-of-kin if a deceased registrant has no other surviving family member listed in this subsection; (3-20-04)

f. 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; ~~and~~ (3-20-04)()

g. 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~~ (3-20-04)()

h. 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. ()

04. Parent. Does not include a biological parent whose parental rights have been terminated. (3-20-04)

05. Public Health. The science and art of: (3-20-04)

a. Preventing disease, prolonging life, or promoting health and efficiency through organized community effort for the sanitation of the environment; (3-20-04)

b. The control of communicable infections; (3-20-04)

c. The education of the individual in personal hygiene; (3-20-04)

d. The organization of medical and nursing services for the early diagnosis and preventive treatment of disease; and (3-20-04)

e. The development of the social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity. (3-20-04)

06. Putative Father. The biological father of a child as identified by himself, the natural mother, an adoption agency, or a court. (3-20-04)

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. (3-20-04)

08. Research. Organized scientific inquiry or examination of data in order to discover and interpret facts. (3-20-04)

09. Statistical Purposes. The collection, analysis, interpretation and presentation of masses of non-identifying numerical information. (3-20-04)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.01 - CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 16-1629, 16-2102, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code; Public Law 113-183 (the Preventing Sex Trafficking and Strengthening Families Act); 42 U.S.C. 673(a)(1)(B)(ii), and 42 U.S.C. 673(a)(3).

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

This rulemaking aligns this chapter of rules with federal requirements for guardianships and adoption assistance programs, as well as relative notification for foster care.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2015, Idaho Administrative Bulletin, [Vol. 15-9, pages 140 through 145](#).

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

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

This rulemaking has no fiscal impact to the state general fund, or any other funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Stephanie Miller at (208) 334-5697.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 16-1629, 16-2102, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code; Public Law 113-183 (the Preventing Sex Trafficking and Strengthening Families Act); 42 U.S.C. 673(a)(1)(B)(ii), and 42 U.S.C. 673(a)(3).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2015.

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

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

This rulemaking is needed to align this chapter of rules with federal requirements for guardianships and adoption assistance programs, as well as relative notification for foster care.

Specifically, these rule changes:

- 1) Clarify the requirements regarding adoption assistance and notification to relatives of children who are placed in foster care; and
- 2) Allow the transfer of relative guardianship assistance benefits to a child's new guardian upon the death or incapacitation of the child's guardian.

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

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

This rulemaking has no fiscal impact to the state general fund, or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these rules are being amended to align with federal requirements and so are nonnegotiable.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Stephanie Miller at (208) 334-5697 or email at MillerS2@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 September 23, 2015.

DATED this 7th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0601-1501

013. DEFINITIONS AND ABBREVIATIONS S THROUGH Z.

For the purposes of these rules, the following terms are used: (5-8-09)

01. SSI (Supplemental Security Income). Income maintenance grants for eligible persons who are aged, blind, or disabled. These grants are provided under Title VI of the Social Security Act and are administered by the Social Security Administration and local Social Security Offices. (3-18-99)

02. Safety Assessment. A process and standardized tool for contact between a family services worker and a family to objectively determine if safety threats, or immediate service needs exist that require further Child and Family Services response. (4-7-11)

03. Safety Plan. Plan developed by the Department and a family which assures the immediate safety of a child who has been determined to be conditionally safe or unsafe. (3-30-01)

04. Sibling. One of two (2) or more persons who shares the same biological or adoptive mother or father, or both. Siblings may be full-siblings or half-siblings. Siblings include those children who would be considered a sibling if not for the disruption in parental rights due to termination of parental rights or the death of a parent. ()

045. State-Funded Guardianship Assistance. Benefits described in Subsection 702.04 and Section 704 of these rules provided to a legal guardian for the support of a child who meets the eligibility criteria. (4-7-11)

056. TAFL. Temporary Assistance to Families in Idaho. (3-18-99)

067. Title IV-E. Title under the Social Security Act which provides funding for foster care maintenance and adoption assistance payments for certain eligible children. (3-20-04)

078. Title IV-E Foster Care. Child care provided in lieu of parental care in a foster home, children's agency, or institution eligible to receive Aid to Dependent Children under Title IV-E of the Social Security Act. (5-8-09)

089. Title XIX (Medicaid). Title under the Social Security Act which provides "Grants to States for Medical Assistance Programs." (3-18-99)

109. Title XXI. (Children's Health Insurance Program). Title under the Social Security Act which provides access to health care for uninsured children under the age of nineteen (19). (3-18-99)

101. Tribal Court. A court with jurisdiction over child custody proceedings and which is either a Court of Indian Offenses, a court established and operated under the code or custom of an Indian tribe, or any other administrative body of a tribe which is vested with authority over child custody proceedings. (3-18-99)

142. Unmarried Parents' Services. Services aimed at achieving or maintaining self-reliance or self-support for unmarried parents. These services include counseling for any unmarried parents who need such service in relation to their plans for their children and arranging for and paying for prenatal and confinement care for the well-being of the parent and infant. Services for unmarried parents are provided in accordance with Section 56-204A, Idaho Code. (5-8-09)

123. Voluntary Services Agreement. A written and executed agreement between the Department and parents or legal guardians regarding the goal, areas of concern, desired results, and task responsibility, including payment. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

702. CONDITIONS FOR GUARDIANSHIP ASSISTANCE.

The following conditions must be met for a child to be eligible for federally-funded or state-funded guardianship assistance. (4-7-11)

01. Assessment of Suitability. The Department or its contractor will determine the suitability of an individual to become a legal guardian for a specific child or sibling group through a guardianship study. (4-7-11)

02. Eligibility for Guardianship Assistance. The Department will determine eligibility for guardianship assistance for each child placed in the legal custody of the Department prior to the finalization of the guardianship. The child will first be considered for eligibility for a federally-funded subsidy. Should the child be found ineligible for a federally-funded subsidy, the child will then be considered for a state-funded subsidy. (4-7-11)

03. Guardianship and Foster Care Licensure. To receive guardianship assistance, a potential legal guardian must apply for and receive a foster care license. (4-7-11)

04. Guardianship Assistance Agreements and Payments. The Department and the prospective legal guardian must enter into a written agreement prior to the finalization of the guardianship. Benefits may include both a monthly cash payment and Medicaid benefits. The cash payment may not exceed the published foster care rate a child would receive if living in family foster care in Idaho. Eligibility for guardianship assistance is based on the child's needs. No means test may be applied to the prospective legal guardian family's income or resources in a determination of eligibility. The Department will provide the prospective legal guardian with a copy of the agreement. All Guardianship Assistance Agreements must contain the following: (4-7-11)

a. The amount and manner in which the guardianship assistance payment will be provided to the prospective legal guardian; (4-7-11)

b. The manner in which the payment may be adjusted periodically in consultation with the legal guardian, based on the circumstances of the legal guardian and the needs of the child; (4-7-11)

c. Any additional services and assistance for which the child and legal guardian will be eligible under the agreement; (4-7-11)

d. The procedure by which the legal guardian may apply for additional services; (4-7-11)

e. A statement that the agreement will remain in effect without regard to the state of residency of the legal guardian; (4-7-11)

f. The procedure by which the Department will make a mandatory annual evaluation of the need for continued assistance and the amount of the assistance; and (4-7-11)

g. Guardianship assistance payments are prospective only. There will be no retroactive benefits or payments. (4-7-11)

h. In Title IV-E Relative Guardianship Assistance Agreements, the prospective relative guardian may identify a successor legal guardian to be appointed guardianship of the child due to the death or incapacitation of the relative legal guardian. ()

05. Termination of Guardianship Assistance. Federally-funded or state-funded guardianship assistance benefits and cash payments are automatically terminated when: (4-7-11)

a. A court terminates the legal guardianship or removes the legal guardian; (4-7-11)

b. The child no longer resides in the home of the legal guardian, and the legal guardian no longer provides financial support for the child; (4-7-11)

c. The child has reached the age of eighteen (18) years, regardless of the child's educational status or physical or developmental delays; or (4-7-11)

d. The child marries, dies, or enters the military. (4-7-11)

e. Title IV-E relative guardianship assistance benefits do not end upon the death or incapacitation of the relative legal guardian if the relative legal guardian identified a successor legal guardian in the child's Title IV-E Relative Guardianship Assistance Agreement and the successor legal guardian assumes legal responsibility for the child. ()

06. Administrative Review for Guardianship Assistance. The prospective legal guardian has twenty-eight (28) days from the date of the Department's notification of the guardianship assistance determination, to request an administrative review. The determination will be reviewed by the FACS Division Administrator, and a decision will be rendered to either affirm, reverse, or modify, the decision. The Department will notify the individual, by mail, of the FACS Division Administrator's decision, of his right to appeal, and procedures for filing an appeal according to requirements in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (4-7-11)

703. FEDERALLY-FUNDED GUARDIANSHIP ASSISTANCE ELIGIBILITY, REQUIREMENTS, AND BENEFITS.

In addition to Section 702 of these rules, the following requirements and benefits are applicable to a federally-funded guardianship assistance for an eligible child and a relative guardian. (4-7-11)

01. Eligibility. A child is eligible for a federally-funded guardianship if the Department determines the child meets the following: (4-7-11)

a. Is fourteen (14) years of age, or older, sometime during the consecutive six- (6) month residence with the prospective relative legal guardian as specified in Subsection 703.01.c. of this rule; (4-7-11)

b. Has been removed from his or her home pursuant to a voluntary placement agreement, or as a result of a judicial determination that continuation in the home would be contrary to the welfare of the child; (4-7-11)

c. Being returned home or adopted are not appropriate permanency options for the child; (4-7-11)

d. Has been eligible for Title IV-E foster care maintenance payments during at least six (6) consecutive months during which the child resided in the home of the prospective relative legal guardian who was licensed or approved as meeting the licensure requirements as a foster family home. While it is not required that Title IV-E foster care maintenance payments have been paid on behalf of the child during the six-month timeframe, it is required the child meet all Title IV-E foster care maintenance payment eligibility criteria in the home of the fully licensed or approved relative foster parent for a consecutive six- (6) month period to be eligible for Title IV-E guardianship assistance payment with that prospective relative legal guardian; (4-7-11)

e. Has been consulted regarding the legal guardianship arrangement; and (4-7-11)

f. Has demonstrated a strong attachment to the prospective relative legal guardian, and the relative legal guardian has a strong commitment to caring permanently for the child. (4-7-11)

g. When a successor legal guardian has been named in the child's most recent Title IV-E Relative Guardianship Assistance Agreement, the child remains eligible for guardianship assistance benefits upon the death or incapacitation of the relative legal guardian with any cash assistance paid to the successor legal guardian. ()

02. Siblings of an Eligible Child. (4-7-11)

a. The Department may make guardianship assistance payments in accordance with a guardianship assistance agreement on behalf of each sibling of an eligible child, under the age of eighteen (18), who is placed with the same relative under the same legal guardianship arrangement if the Department and the relative legal guardian agree that the placement is appropriate. (4-7-11)

b. Nonrecurring expenses associated with obtaining legal guardianship of the eligible child's siblings are available to the extent the total cost does not exceed two thousand dollars (\$2,000). (4-7-11)

c. The agency is not required to place siblings with the relative legal guardian of the child at the same time with the eligible child for the siblings to qualify for a cash payment. (4-7-11)

d. A sibling of the eligible child does not have to meet the eligibility criteria for the relative legal guardian to receive a guardianship assistance payment or for the relative legal guardian to receive nonrecurring expenses. (4-7-11)

03. Medicaid. A child who is eligible for federally-funded relative guardianship assistance is eligible for Title XIX Medicaid in the state where the child resides. (4-7-11)

04. Case Plan Requirements. A child who is eligible for federally-funded relative guardianship assistance must have a case plan that includes: (4-7-11)

a. How the child meets the eligibility requirements; (4-7-11)

b. Steps the agency has taken to determine that return to the home or adoption is not appropriate; (4-7-11)

c. The efforts the agency has made to discuss adoption with the child's relative foster parent and the reason why adoption is not an option; (4-7-11)

d. The efforts the agency has made to discuss the legal guardianship and the guardianship assistance with the child's parent or parents, or the reason the efforts were not made; (4-7-11)

e. The reason why a permanent placement with a prospective relative legal guardian and receipt of a guardianship assistance payment is in the child's best interests; and (4-7-11)

f. If the child is not placed with siblings, a statement as to why the child is separated from his siblings. (4-7-11)

05. Criminal History and Background Checks. To be eligible for a federally-funded guardianship assistance payment, all prospective legal guardians and other adult members of the household must receive a criminal history and background check clearance, according to the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." As a licensed foster parent, if the prospective relative legal guardian has already received a clearance, another check is not necessary. (4-7-11)

06. Nonrecurring Expenses. The Department will reimburse the cost, up to two thousand dollars (\$2,000), of nonrecurring expenses associated with obtaining a federally-funded legal guardianship for an eligible child. (4-7-11)

(BREAK IN CONTINUITY OF SECTIONS)

911. ADOPTION ASSISTANCE PROGRAM AGREEMENT.

A written agreement must be negotiated and fully executed between the Department and adopting family prior to the finalization of adoption and implementation of benefits. (5-8-09)

01. Agreement Specifications. The agreement specifies the following: (5-8-09)

a. The type and amount of assistance to be provided; (5-8-09)

b. That there will be an annual review of each agreement by the Department to evaluate the need for

continued subsidy and the amount of the subsidy; (5-8-09)

c. That the agreed upon type and amount of assistance may be adjusted only with the concurrence of the adoptive parent(s) based upon changes in the needs of the child or changes in the circumstances of the adoptive family; (5-8-09)

~~d. That assistance is subject to the continuing availability of funds; and~~ (5-8-09)

~~ed.~~ That the adoptive parent(s) are required to inform the Department of any circumstances which would make them ineligible for adoption assistance payments, or eligible for adoption assistance payments in a different amount. (5-8-09)

02. Termination of Adoption Assistance. Adoption assistance will be terminated if the adoptive parent(s) no longer have legal responsibility for the child as a result of termination of parental rights, the child is no longer receiving any financial support from the parents, or the child has reached the age of eighteen (18) years regardless of the child's educational status. (4-11-06)

03. Adoption Assistance Follows the Child. If the adoptive parents are located in a state other than Idaho, or move out of Idaho with the child, the adoption assistance payments initiated by Idaho will continue for the child. If the child is IV-E or state-funded adoption assistance eligible, referral for Medicaid or other state medical insurance and social service benefits will be forwarded to the new state of residence through the Interstate Compact on Adoption and Medical Assistance. Non IV-E eligible children receiving a state adoption subsidy, may not be eligible for Medicaid in a state other than Idaho. (5-3-03)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.06.02 - RULES GOVERNING STANDARDS FOR CHILD CARE LICENSING

DOCKET NO. 16-0602-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the effective date of the rule.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-1111, 39-1209, 39-1210, 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code, and Public Law 113-183 (the Preventing Sex Trafficking and Strengthening Families Act).

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

This rulemaking aligns this chapter of rules with federal requirements regarding foster care and the application of the “reasonable and prudent parent standard.” In this rulemaking:

1. The term “reasonable and prudent parent standard” is being defined for the purpose of the Department’s child welfare program. The definition is required in accordance with Public Law 113-183 and the proposed definition utilizes wording acceptable to the federal Department of Health and Human Services.
2. Public Law 113-183 requires child care institutions providing foster care to have the presence of at least one on-site official who, with respect to any child placed at the child care institution, is designated to be the caregiver who is authorized to apply the reasonable and prudent parent standard.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2015, Idaho Administrative Bulletin, [Vol. 15-9, pages 146 and 147](#).

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

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

This rulemaking has no fiscal impact to the state general fund, or any other funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sabrina Brown at (208) 334-5648.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-1111, 39-1209, 39-1210, 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code, and Public Law 113-183 (the Preventing Sex Trafficking and Strengthening Families Act).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2015.

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

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

This rulemaking is being done to align this chapter of rules with federal requirements regarding foster care and the application of the “reasonable and prudent parent standard.”

In this rulemaking:

- 3) The term “reasonable and prudent parent standard” is being defined for the purpose of the Department’s child welfare program. The definition is required in accordance with Public Law 113-183 and the proposed definition utilizes wording acceptable to the federal Department of Health and Human Services.
- 4) Public Law 113-183 requires child care institutions providing foster care to have the presence of at least one on-site official who, with respect to any child placed at the child care institution, is designated to be the caregiver who is authorized to apply the reasonable and prudent parent standard.

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

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

This rulemaking has no fiscal impact to the state general fund, or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these rules are being amended to align with federal requirements and so are nonnegotiable. Failure to make these rule changes will result in loss of funding.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sabrina Brown at (208) 334-5648 or email at BrownS5@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 September 23, 2015.

DATED this 7th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0602-1501

457. REASONABLE AND PRUDENT PARENT STANDARD.

A caregiver must follow the reasonable and prudent parent standard. ()

01. Reasonable and Prudent Parent Standard Defined. The reasonable and prudent parent standard means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child that a caregiver must use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, or social activities. ()

a. “Caregiver” means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed. ()

b. “Age or developmentally appropriate” means: ()

i. Activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and ()

ii. In the case of specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child. ()

02. Training. Each caregiver will complete training to include knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally appropriate activities, including knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child, and applying the standard to decisions such as whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities, including sports, field trips, and overnight activities lasting one (1) or more days, and involving the signing of permission slips and arranging transportation for the child to and from extracurricular enrichment and social activities. ()

~~457~~**8.** -- 469. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

583. REASONABLE AND PRUDENT PARENT STANDARD FOR AN ORGANIZATION PROVIDING SERVICES TO CHILDREN PLACED BY THE DEPARTMENT.

An organization providing services to children placed by the Department’s Child and Family Service Program must designate at least one (1) on-site official who is authorized to apply the reasonable and prudent parent standard as described in Section 457 of these rules. ()

~~583~~**4.** -- 599. (RESERVED)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.01 - BEHAVIORAL HEALTH SLIDING FEE SCHEDULES

DOCKET NO. 16-0701-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Title 39, Chapter 3, and Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

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

There are no changes to the pending rule combining the fee schedules into one table and updating to a behavioral health system of care. These rules are being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2015, Idaho Administrative Bulletin, [Vol. 15-9, pages 148 through 155](#).

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

There is no anticipated fiscal impact to the state general funds or any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Treena Clark at (208) 334-6611.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 39, Chapter 3, and Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2015.

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

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

The Department is integrating behavioral health services to better match current practices for children's mental health, adult mental health, and substance use disorders services. These rules amendments combine the fee schedules into one table, remove obsolete language and tables, and update references for behavioral health services to rates set in Department contracts.

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

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

This rulemaking has no fiscal impact to the state general fund, or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these rule changes are needed to update and align this chapter with other Department rules and contracts which makes these rules nonnegotiable.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Trenea Clark at (208) 334-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2015.

DATED this 7th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0701-1501

000. LEGAL AUTHORITY.

Under Sections 16-2433, 19-2524, ~~20-520(i)~~, 20-511A, and 39-3137, Idaho Code, the Director is authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers. Under Section 39-309, Idaho Code, the Board of Health and Welfare is authorized to promulgate, adopt, and enforce rules for the charging of fees for services provided by mental health and substance use disorders providers. ~~(4-9-09)~~ ()

(BREAK IN CONTINUITY OF SECTIONS)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEB SITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (4-9-09)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (4-9-09)

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (4-9-09)

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (4-9-09)

05. Internet Web Site. The Department's internet website at <http://www.healthandwelfare.idaho.gov>. (4-9-09)

06. Substance Use Disorders Services Website. The Substance Use Disorders Services internet website at <http://www.substanceabuse.idaho.gov>. ()

07. Mental Health Services Website. The Mental Health Services internet website at <http://www.mentalhealth.idaho.gov>. ()

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

For the purposes of this chapter, the following definitions apply. (4-9-09)

01. Ability to Pay. The financial capacity that is available to pay for the program services after allowable deductions in relation to gross income and family size exclusive of any liability of third party payor sources. (4-9-09)

02. Adjusted Gross Income. Total family annual income less allowable annual deductions. (4-9-09)

03. Adult. An individual 18 years of age or older. (4-9-09)

04. Adult Mental Health Program. A program administered by the Idaho Department of Health and Welfare to serve seriously mentally ill and severely and persistently mentally ill adults. ~~(4-9-09)~~ ()

05. Allowable Annual Deductions. In determining the family's ability to pay for behavioral health services, the following are allowable annual deductions: (4-9-09)

a. Court-ordered obligations; (4-9-09)

b. Dependent support; (4-9-09)

c. Child care payments necessary for parental employment; (4-9-09)

d. Medical expenses. (4-9-09)

e. Transportation; (4-9-09)

f. Extraordinary rehabilitative expenses; and (4-9-09)

g. State and federal tax payments, including FICA taxes. (4-9-09)

06. Behavioral Health Services. Services offered by the Department to improve behavioral mental health ~~issues or alcohol~~ and substance use disorders issues. ~~(4-9-09)~~ ()

- 07. Child.** An individual who is under the age of eighteen (18) years. (4-9-09)
- 08. Children's Mental Health Program.** A program as defined in IDAPA 16.07.37, "Children's Mental Health Services," administered by the Idaho Department of Health and Welfare. (4-9-09)
- ~~**09. Client.** The recipient of services. The term "client" is synonymous with the terms: patient, participant, resident, consumer, or recipient of treatment. (4-9-09)~~
- ~~**109. Court-Ordered Obligations.** Financial payments which have been ordered by a court of law. (4-9-09)~~
- ~~**110. Court-Ordered Recipient.** A person receiving behavioral health services under Sections 19-2524, 20-520(i), and 20-511A, Idaho Code. (4-9-09)~~
- ~~**121. Department.** The Idaho Department of Health and Welfare. (4-9-09)~~
- ~~**132. Dependent Support.** An individual that is dependent on his family's income for over fifty percent (50%) of his financial support. (4-9-09)~~
- ~~**143. Extraordinary Rehabilitative Expenses.** Those payments incurred as a result of the disability needs of the person receiving services. They include annual costs for items including, but not limited to, wheelchairs, adaptive equipment, medication, treatment, or therapy which were not included in the medical payments deduction and the annual estimate of the cost of services received. (4-9-09)~~
- ~~**154. Family.** A family is an adult, or married adults, or adult(s) with children, living in a common residence. (4-9-09)~~
- ~~**165. Family Household.** Persons in a family related by blood, marriage, or adoption. Adult siblings who are not claimed as dependents and individuals receiving Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI) are excluded from consideration as a member of the household for income and counting purposes. Income from minor siblings is excluded from household income. The term "family household" is synonymous with the term "family unit." (3-29-10)~~
- ~~**176. Federal Poverty Guidelines.** Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found online at <http://aspe.hhs.gov/poverty>. (4-9-09)~~
- ~~**187. Management Service Contractor (MSC).** An independent contractor with whom the Department contracts to manage a statewide network of Department-approved facilities and programs to deliver substance use disorders treatment and recovery support services. (7-1-13)~~
- ~~**198. Parent.** The person who, by birth or through adoption, is legally responsible for a child. (4-9-09)~~
- ~~**2019. Recipient.** The person receiving services. The term "recipient" is synonymous with the terms: "patient," "participant," "resident," "consumer," or "client." (4-9-09)~~
- ~~**240. Sliding Fee Scale.** A scale used to determine an individual's financial obligation for services based on Federal Poverty Guidelines and the number of persons in the family household. (4-9-09)~~
- ~~**221. Substance Use Disorders Program.** A program administered by the Idaho Department of Health and Welfare to serve adolescents and adults with alcohol or substance use disorders. (4-9-09)~~
- ~~**232. Third-Party Payor.** A payor other than a person receiving services or a responsible party who is legally liable for all or part of the person's care. (4-9-09)~~

(BREAK IN CONTINUITY OF SECTIONS)

300. SLIDING FEE SCHEDULE FOR CHILDREN'S MENTAL HEALTH, ~~AND~~ ADULT MENTAL HEALTH, AND SUBSTANCE USE DISORDERS SERVICES.

Following is the sliding fee schedule for children's mental health, ~~and~~ adult mental health, and substance use disorders services:

TABLE 300 - SLIDING FEE SCHEDULE FOR CHILDREN'S MENTAL HEALTH, AND ADULT MENTAL HEALTH, AND SUBSTANCE USE DISORDERS SERVICES.	
Percent Federal of Poverty Guidelines	Percentage of Cost Sharing Responsibility of a Parent, or Adult Client Services Recipient
0% - 99%	0%
100%-109%	5%
110%-119%	10%
120%-129%	15%
130%-139%	20%
140%-149%	25%
150%-159%	30%
160%-169%	35%
170%-179%	40%
180%-189%	45%
190%-199%	50%
200% - 209%	55%
210% - 219%	60%
220% - 229%	65%
230% - 239%	70%
240% - 249%	75%
250% - 259%	80%
260% - 269%	85%
270% - 279%	90%
280% - 289%	95%
290% - and above	100%

(4-9-09)()

301. -- 399. (RESERVED)

400. CALCULATING INCOME TO APPLY THE SLIDING FEE SCHEDULE FOR CHILDREN'S MENTAL HEALTH AND ADULT MENTAL HEALTH SERVICES.

The fee determination process includes consideration of the following subsections in this rule. ()

01. Application And Fee Determination Form. Prior to the delivery of behavioral health services, an application for services and a "Fee Determination" form must be completed ~~by~~. ()

a. ~~a~~**A** child's parent(s) must complete the application and fee determination form when requesting Children's Mental Health services ~~and by~~. ()

b. An adults requesting Adult Mental Health services must complete the application and fee determination form. ~~The fee determination process includes the following considerations:~~ (4-9-09)()

042. Ability to Pay. Financial obligations are based upon the number of persons in the family household and the adjusted gross income of those persons as determined using the following: (4-9-09)

a. An ability to pay determination will be made at the time of the voluntary request for services or as soon as possible, thereafter. (4-9-09)

b. Redetermination of ability to pay will be made at least annually or upon request ~~of the parent(s)~~ or at any time changes occur in family size, income, or allowable deductions. (4-9-09)()

c. In determining the family's ability to pay for services, the Department will deduct annualized amounts for the following: (4-9-09)

- i. Court-ordered obligations; (4-9-09)
- ii. Dependent support; (4-9-09)
- iii. Child care expenses necessary for parental employment; (4-9-09)
- iv. Medical expenses; (4-9-09)
- v. Transportation; (4-9-09)
- vi. Extraordinary rehabilitative expenses; and (4-9-09)
- vii. State and federal tax payments, including FICA taxes. (4-9-09)

023. Required Information. Information regarding third-party payors and other resources, including Medicaid or private insurance, must be identified and developed in order to fully determine the child's parent(s) or adult ~~client's~~ individual's ability to pay and to maximize reimbursement for the cost of services provided. It is the responsibility of the parents, legal guardian, or adult ~~client~~ individual to obtain and provide information not available at the time of the initial financial interview whenever that information becomes available. (4-9-09)()

034. Time of Payment. Payment for services will be due upon delivery of services unless other arrangements are made. (4-9-09)

045. Financial Obligation. A financial obligation for each service not covered by third party liable resources or payments, including private insurance and Medicaid, will be established in accordance with Section 300 and Subsection 400.01 of these rules but in no case will the amount owed exceed the cost of the service. In no case will the annual financial obligation exceed five percent (5%) of adjusted gross income of the family household. (4-9-09)

056. Fees Established By the Department. The maximum hourly fees or flat fees charged for ~~Children's Mental Health services and Adult Mental~~ Behavioral Health services are established by the Department of Health and Welfare. ~~The fees for services based on Medicaid reimbursement rates may vary according to Medicaid inflationary increases. Fees will be reviewed and adjusted as the Medicaid rates change. Current information regarding services and fee charges can be obtained from regional Children's Mental Health and Adult Mental Health offices.~~ (4-9-09)()

a. The fees for Children's Mental Health Services and Adult Mental Health Services are based on the cost for services set in Department contracts with service providers. Current information regarding services and fee

charges can be obtained from regional Children's Mental Health and Adult Mental Health offices specified online as described in Section 005 of these rules. ()

b. The fees for Substance Use Disorders Services are based on the cost for services set in Department contracts with the Management Services Contractor. Current information regarding services and fee charges can be obtained from the Department office described in Section 005 of these rules. ()

~~401. 499. (RESERVED)~~

~~500. SLIDING FEE SCHEDULE FOR ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT SERVICES.~~

~~Adult clients above two hundred percent (200%) of federal poverty guidelines are not eligible for services. Following is the sliding fee schedule for adolescent and adult alcohol and substance use disorders treatment services:~~

TABLE 500 - SLIDING FEE SCHEDULE FOR ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT SERVICES	
Percent of Federal Poverty Guidelines	Percentage of Cost-Sharing Responsibility of a Parent, Guardian, or Adult Service Recipient
0% 99% or a Medicaid Client	0%
100% 109%	5%
110% 119%	10%
120% 129%	15%
130% 139%	20%
140% 149%	25%
150% 159%	30%
160% 169%	35%
170% 179%	40%
180% 189%	45%
190% 199%	50%
200%	55%

~~(4-9-09)~~

~~501. 599. (RESERVED)~~

~~600. CALCULATING INCOME TO APPLY THE SLIDING FEE SCHEDULE FOR ALCOHOL AND SUBSTANCE DISORDERS SERVICES.~~

~~01. Ability to Pay. Charges are based upon the number of dependents and family income. (4-9-09)~~

~~a. An ability to pay determination will be made at the time of the voluntary request for services or as soon as possible. (4-9-09)~~

~~b. Redetermination of ability to pay will be made at least annually or upon request demonstrating that a substantial material change of circumstances has occurred in family size, income, or allowable deductions. (4-9-09)~~

- ~~c.~~ *In determining an individual's ability to pay for services, the Department will deduct annualized amounts for:* (4-9-09)
- ~~i.~~ *Court-ordered obligations;* (4-9-09)
 - ~~ii.~~ *Dependent support;* (4-9-09)
 - ~~iii.~~ *Child care payments necessary for employment;* (4-9-09)
 - ~~iv.~~ *Medical expenses;* (4-9-09)
 - ~~v.~~ *Transportation;* (4-9-09)
 - ~~vi.~~ *Extraordinary rehabilitative expenses; and* (4-9-09)
 - ~~vii.~~ *State and federal tax payments, including FICA.* (4-9-09)
- ~~d.~~ *Information regarding third-party payors and other resources including Medicaid, or private insurance must be identified and developed in order to fully determine the individual's ability to pay and to maximize reimbursement for the cost of services provided.* (4-9-09)
- ~~e.~~ *It is the responsibility of the individual requesting alcohol or substance use disorder services to obtain and provide information not available at the time of the initial financial interview whenever that information becomes available.* (4-9-09)
- ~~02.~~ ***Time of Payment.*** *Payment for services is due thirty (30) days from the date of the billing, unless other arrangements are made.* (4-9-09)
- ~~03.~~ ***Charges.*** *Using the sliding fee scale in Section 500 of this rule, an amount will be charged based on family size, resources, income, assets, and allowable deductions, exclusive of third-party liable sources. In no case will the amount charged exceed the costs of the services.* (4-9-09)
- ~~04.~~ ***Established Fee.*** *The maximum hourly fees or flat fees charged for alcohol or substance use disorder services are established by the Department of Health and Welfare. The fees for services are based on the cost for services as set forth in the Department contract with the Management Services Contractor. Current information regarding services and fee charges can be obtained from the Department office as specified in Section 005 of these rules.* (7-1-13)
- 6401. -- 999. (RESERVED)**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.07.10 - BEHAVIORAL HEALTH DEVELOPMENT GRANTS

DOCKET NO. 16-0710-1501 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This action is authorized pursuant to Title 39, Chapter 31, Idaho Code.

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

With the passage of legislation to create regional behavioral health boards and community crisis centers the Department is developing a behavioral health system of care that eliminates the need for the Behavioral Health Development Grants. There are no changes to the pending rule, and the rule is being adopted as originally proposed. The Notice of Repeal of the entire chapter published in the September 2, 2015, Idaho Administrative Bulletin, **Vol. 15-9, page 156**.

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:

Funds appropriated for Behavioral Health Development Grants in 2009 have been disbursed and no additional funds have been appropriated for this program in the past five years. There is no anticipated fiscal impact to the state general fund, or any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 30th day of October, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 39, Chapter 3, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2015.

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

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

This chapter is being repealed in its entirety. With the passage of legislation to create regional behavioral health boards and community crisis centers the Department is developing a behavioral health system of care that eliminates the need for the Behavioral Health Development Grants.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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:

Funds appropriated for Behavioral Health Development Grants in 2009 have been disbursed and no additional funds have been appropriated for this program in the past five years. There is no anticipated fiscal impact to the state general fund, or any other funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this chapter of rule for Behavioral Health Development Grants is being repealed due to no funding for these grants making the rulemaking nonnegotiable.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Trenea Clark at (208) 334-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2015.

DATED this 7th Day of August, 2015.

LSO Rules Analysis Memo

<p>THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0710-1501</p>
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IDAPA 16.07.10 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.07.17 - ALCOHOL AND SUBSTANCE USE DISORDERS SERVICES
DOCKET NO. 16-0717-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Title 39, Chapter 3, Idaho Code.

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

Alcohol and substance use disorders treatment and recovery support services and program requirements from a chapter repeal have been added to this chapter of rules. Changes have been made to the proposed rules to clarify definitions, terminology, and references. The complete text of the proposed rule was published in the September 2, 2015, Idaho Administrative Bulletin, [Vol. 15-9, pages 178 through 200](#).

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

There is no anticipated fiscal impact to the state general funds or any other funds due to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Treena Clark at (208) 334-6611.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 39, Chapter 3, Idaho Code.

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

ORIGINATING LOCATION -- LIVE MEETING

Thursday, September 17, 2015
10:00 a.m. (MDT) / 9:00 a.m. (PDT) and
2:00 p.m. (MDT) / 1:00 p.m. (PDT)

Idaho Department of Health & Welfare -- Central Office
Conf. Room 3A (3rd Floor)
450 West State Street
Boise, ID 83702

VIDEO CONFERENCING

Region I Office – Coeur d’Alene
Main Conference Room
2195 Ironwood Court
Coeur d’Alene, ID 83814

Region II Office - Lewiston
1st Floor Conference Room
1118 “F” Street
Lewiston, ID 83501

Region III Office - Caldwell
Owyhee Conference Room (Rm
226)
3402 Franklin Road
Caldwell, ID 83605

Region IV Office - Boise
Room 131
1720 Westgate Drive, Suite A
Boise, ID 83704

Region V Office - Twin Falls
Room 116
823 Harrison
Twin Falls, ID 83301

Region VI Office - Pocatello
Room 225
421 Memorial Drive
Pocatello, ID 83201

Region VII Office - Idaho Falls
Conference Room 240
150 Shoup Ave.
Idaho Falls, ID 83402

State Hospital South - Blackfoot
Admin. Bldg., Classroom A09
700 E. Alice Street
Blackfoot, ID 83221

State Hospital North
Administration Conf. Rm. 234
300 Hospital Drive
Orofino, ID 83544

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

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

The Department is moving towards an integrated Behavioral Health Program that includes mental health and alcohol and substance use disorders treatment and recovery support services and programs. Changes are being made to this chapter to include adding services and programs from the IDAPA 16.07.20, “Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs,” chapter that is being repealed in this Bulletin under Docket 16-0720-1501.

Substance use disorders recovery services and treatment programs and requirements have been added into this chapter that include: case management, alcohol and drug screening, child care, transportation, life skills, staffed safe and sober housing for adolescents and staffed safe and sober housing for adults.

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

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

There is no anticipated fiscal impact to the state general funds or any other funds due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 6, 2015, Idaho Administrative Bulletin, [Vol.15-5, pages 62-63](#) under Docket No. 16-0720-1501. The Department held three meetings around the state and also allowed participants to conference call into the meetings.

INCORPORATION BY REFERENCE: The following documents have been incorporated by reference into these rules:

American Society of Addiction Medicine (ASAM), Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, updated from 2nd Edition, to 3rd Edition, 2013. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, updated from 4th Edition to 5th Edition. Guidelines for the Accreditation of Opioid Treatment Programs (OTP) have been added.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 334-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2015.

DATED this 7th Day of August, 2015.

LSO Rules Analysis Memo

Italicized red text that is double underscored is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0717-1501

000. LEGAL AUTHORITY.

The Idaho Legislature has delegated to the Department and the Board of Health and Welfare, the responsibility ~~to ensure that clinically necessary alcohol and~~ to establish and enforce rules for a comprehensive and coordinated program for the treatment of substance use disorders. ~~services are available throughout the state of Idaho to individuals who meet certain eligibility criteria under the Alcoholism and Intoxication Treatment Act. This authority is found in the Alcoholism and Intoxication Treatment Act.~~ Title 39, Chapter 3, and Section 56-1003, Idaho Code. ~~Under Section 39-311, Idaho Code, the Board of Health and Welfare is authorized to promulgate rules to carry out the purpose and intent of the Alcoholism and Intoxication Treatment Act. Under Section 39-304, Idaho Code, the Department is authorized to establish a comprehensive and coordinated program for the treatment of alcoholics, intoxicated persons, and drug addicts to carry out the purposes and intent of the Alcoholism and Intoxication Treatment Act. Section 56-1003, Idaho Code authorizes the Director of the Department to administer services dealing with the problem of alcoholism and the rehabilitation of persons suffering from alcoholism.~~ (5-8-09)()

001. TITLE, ~~AND~~ SCOPE, AND PURPOSE.

01. Title. The title of these rules is, IDAPA 16.07.17, "~~Alcohol and~~ Substance Use Disorders Services." (5-8-09)()

02. Scope. This chapter ~~defines the scope of voluntary~~ sets the standards for providing substance use disorders services administered under the Department's Division of Behavioral Health, ~~and describes the eligibility criteria, application requirements, individualized service plan requirements, selection of providers, and appeal process under these rules. This chapter is not intended to and does not establish an entitlement for or to receive adult or adolescent alcohol or substance use disorder services, nor is it intended to be applicable to individuals ordered by the court to receive alcohol or substance use disorder services.~~ (7-1-13)()

03. Purpose. The purpose of these rules is to: ()

a. Provide participant eligibility criteria, application requirements, and appeals process for services administered under the Department's Division of Behavioral Health; and ()

b. Establish requirements for quality of substance use disorders treatment, care, and services provided by behavioral health and recovery support services programs. ()

002. WRITTEN INTERPRETATIONS.

~~There are no written interpretations for these rules.~~ In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that 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 as described in Sections 005 and 006 of these rules. (5-8-09)()

003. ADMINISTRATIVE APPEALS.

01. Appeal of Denial Based on Eligibility ~~Criteria~~ Requirements. Administrative appeals from a denial of ~~alcohol and~~ substance use disorder services based on eligibility ~~criteria and priority population requirements~~ are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (5-8-09)()

02. Appeal of Decision Based on Clinical Judgement. ~~All~~ Decisions involving clinical judgment, including the category of services, the particular provider of services, or the duration of services, are reserved to the Department, and are not subject to appeal, administratively or otherwise, in accordance with *Maresh v. State*, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). (5-8-09)()

004. INCORPORATION BY REFERENCE.

The following are incorporated by reference in this chapter of rules: (5-8-09)

01. ASAM ~~PPC 2R~~. American Society of Addiction Medicine (ASAM) ~~Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition—Revised (ASAM PPC 2R)~~ Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, 2013. A copy of this manual is available by mail at the American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Chevy Chase, MD 20815; by telephone and fax, (301) 656-3920 and (301) 656-3815 (fax); or on the internet at <http://www.asam.org>. (5-8-09)()

02. DSM-~~IV-TR~~5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, ~~Fourth~~ Fifth Edition, ~~Text Revision~~ (DSM-~~IV-TR~~5) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, ~~1400 K Street, N.W., Washington, DC, 20005. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702~~ 1000 Wilson Boulevard, Suite 1825, Arlington VA 22209-3901. (5-8-09)()

03. Guidelines for the Accreditation of Opioid Treatment Programs (OTP). Substance Abuse and Mental Health Services Administration, Office of Pharmacological and Alternative Therapies, Attention: OTP Certification Program, Room 2-1086, 1 Choke Cherry Road, Rockville, MD 20857; or on the internet at <http://www.dpt.samhsa.gov/regulations/certification.aspx> for an overview of certification regulations, and <http://www.dpt.samhas.gov/pdf/OTPAccredGuidelines-2007.pdf> for specific guidelines dated July 20, 2007. ()

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEB SITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (5-8-09)

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and

Welfare, P.O. Box 83720, Boise, Idaho 83720-0036.

(5-8-09)

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702.

(5-8-09)

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

(5-8-09)

05. Internet Web Site. The Department's internet website at <http://www.healthandwelfare.idaho.gov>.

(5-8-09)

06. Substance Use Disorders Services Website. The Substance Use Disorders Services Internet website at <http://www.substanceabuse.idaho.gov>.

()

(BREAK IN CONTINUITY OF SECTIONS)

007. -- 0082. (RESERVED)

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

~~**01. Compliance With Department Criminal History and Background Check.** All owners, operators, employees, transfers, reinstated former employees, student interns, contractors, and volunteers who provide direct care or services, or whose position requires regular contact with clients, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks."~~

~~(7-1-14)~~

~~**02. Availability to Work or Provide Service.** An individual listed in Subsection 009.01 of these rules is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted his criminal history and background check application, it has been signed and notarized, reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting his criminal history and background check application.~~

~~(7-1-14)~~

~~**a.** An individual is allowed to work or have access to clients only under supervision until the criminal history and background check is completed.~~

~~(7-1-14)~~

~~**b.** An individual, who does not receive a criminal history and background check clearance or a waiver granted under the provisions in this chapter, may not provide direct care or services, or serve in a position that requires regular contact with clients in an alcohol and substance use disorders treatment and recovery support services program.~~

~~(7-1-14)~~

~~**03. Waiver of Criminal History and Background Check Denial.** An individual who receives a conditional or unconditional denial for a criminal history and background check, may apply for a waiver to provide direct care or services, or serve in a position that requires regular contact with clients in an alcohol and substance use disorders treatment and recovery support services program. A waiver may be granted on a case-by-case basis upon administrative review by the Department of any underlying facts and circumstances in each individual case. A waiver will not be granted for crimes listed in Subsection 009.04 of this rule.~~

~~(7-1-14)~~

~~**04. No Waiver for Certain Designated Crimes.** No waiver will be granted by the Department for any of the following designated crimes or substantially conforming foreign criminal violations:~~

~~(7-1-14)~~

~~**a.** Foreible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code;~~

~~(7-1-14)~~

~~**b.** Incest, as defined in Section 18-6602, Idaho Code;~~

~~(7-1-14)~~

- ~~e. Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; (7-1-14)~~
- ~~d. Murder in any degree or assault with intent to commit murder, as defined in Sections 18-4001, 18-4003, and 18-4015, Idaho Code; (7-1-14)~~
- ~~e. Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; (7-1-14)~~
- ~~f. Rape, as defined in Section 18-6101, Idaho Code; (7-1-14)~~
- ~~g. Sale or barter of a child, as defined in Section 18-1511, Idaho Code; (7-1-14)~~
- ~~h. Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; (7-1-14)~~
- ~~i. Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; (7-1-14)~~
- ~~j. Inducing individuals under eighteen (18) years of age into prostitution or patronizing a prostitute, as defined in Sections 18-5609 and 18-5611, Idaho Code; (7-1-14)~~
- ~~k. Any felony punishable by death or life imprisonment; or (7-1-14)~~
- ~~l. Attempt, conspiracy, accessory after the fact, or aiding and abetting, as defined in Sections 18-205, 18-306, 18-1701, and 19-1430, Idaho Code, to commit any of the disqualifying designated crimes. (7-1-14)~~
- ~~05. **Administrative Review.** An administrative review for a waiver may consist of a review of documents and supplemental information provided by the individual, a telephone interview, an in person interview, or any other review deemed necessary by the Department. The Department may appoint a subcommittee to conduct administrative reviews provided for under Subsections 009.03 through 009.12 of this rule. (7-1-14)~~
- ~~06. **Written Request for Administrative Review and Waiver.** A written request for a waiver must be sent to the Administrative Procedures Section, 450 W. State Street, P.O. Box 83720, Boise, Idaho 83720-0026 within fourteen (14) calendar days from the date of the issuance of a denial from the Department's Criminal History Unit. The fourteen (14) day period for submitting a request for a waiver may be extended by the Department for good cause. (7-1-14)~~
- ~~07. **Scheduling of Administrative Review.** Upon receipt of a written request for a waiver, the Department will determine the type of administrative review to be held, and conduct the review within thirty (30) business days from the date of receipt. When an in person review is appropriate, the Department will provide the individual at least seven (7) days notice of the review date. (7-1-14)~~
- ~~08. **Factors Considered During Administrative Review.** During the administrative review, the following factors may be considered: (7-1-14)~~
 - ~~a. The severity or nature of the crimes or other findings; (7-1-14)~~
 - ~~b. The period of time since the incidents occurred; (7-1-14)~~
 - ~~c. The number and pattern of incidents being reviewed; (7-1-14)~~
 - ~~d. Circumstances surrounding the incidents that would help determine the risk of repetition; (7-1-14)~~
 - ~~e. The relationship between the incidents and the position sought; (7-1-14)~~
 - ~~f. Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation. (7-1-14)~~

- ~~g. A pardon that was granted by the Governor or the President; (7-1-14)~~
~~h. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and (7-1-14)~~
~~i. Any other factor deemed relevant to the review. (7-1-14)~~

~~09. **Administrative Review Decision.** A notice of decision will be issued by the Department within fifteen (15) business days of completion of the administrative review. (7-1-14)~~

~~10. **Decision to Grant Waiver.** The Department's decision to grant a waiver does not set a precedent for subsequent requests by an individual for a waiver. A waiver granted under this chapter is not a criminal history and background check clearance, and is only applicable to services and programs governed under this chapter. It does not apply to other Department programs requiring clearance of a criminal history and background check. (7-1-14)~~

~~11. **Revocation of Waiver.** The Department may chose to revoke a waiver at its discretion for circumstances that it identifies as a risk to client health and safety, at any time. (7-1-14)~~

~~12. **Waiver Decisions Are Not Subject to Review or Appeal.** The decision or actions of the Department concerning a waiver is not subject to review or appeal, administratively or otherwise. (7-1-14)~~

~~13. **Employer Responsibilities.** A waiver granted by the Department is not a determination of suitability for employment. The employer is responsible for reviewing the results of a criminal history and background check even when a clearance is issued or a waiver is granted. Making a determination as to the ability or risk of the individual to provide direct care services or to serve in a position that requires regular contact with children and vulnerable adults is the responsibility of the employer. (7-1-14)~~

010. DEFINITIONS - A THROUGH F.

For the purposes of these rules, the following terms are used as defined below: (5-8-09)

01. **Adolescent.** An individual ~~between the ages of fourteen (14) and~~ under the age of eighteen (18) ~~years.~~ (5-8-09)()

02. **Adult.** An individual eighteen (18) years or older. (5-8-09)

03. **Applicant.** An adult or adolescent individual who is seeking alcohol or substance use disorders services through the Department who has completed or had completed on his behalf an application for alcohol or substance use disorder services. (5-8-09)

04. **ASAM ~~PPC-2R~~.** Refers to the ~~second~~ third edition ~~revised,~~ manual of the patient placement criteria for the treatment of substance-related disorders, published by the American Society of Addiction Medicine, incorporated by reference in Section 004 of these rules. ~~(5-8-09)()~~

~~05. **Assessment and Referral Services.** A substance use disorders program provides these services in order to treat, provide services, or refer individuals. An assessment is designed to gather and analyze information regarding a client's current substance use disorder behavioral, social, medical, and treatment history. The purpose of the assessment is to provide sufficient information for problem identification and, if appropriate, substance use disorder related treatment or referral. (7-1-13)~~

~~06. **Child.** An individual under the age of fourteen (14) years. (7-1-13)~~

~~07. **Client.** A person receiving treatment for an alcohol or substance use disorder. The term "client" is synonymous with the terms: patient, resident, consumer, or recipient of treatment. (5-8-09)~~

05. **Clinical Assessment.** The gathering of historical and current clinical information through a clinical interview and from other available resources to identify an individual's strengths, weaknesses, problems, needs, and determine priorities so that a service plan can be developed. ()

~~086.~~ **Clinical Judgment.** Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes ~~and alcohol~~ and substance use disorders service needs. (5-8-09)()

~~097.~~ **Clinical Necessity.** ~~Alcohol or s~~Substance use disorder services are deemed clinically necessary when the Department, in the exercise of clinical judgment, would recommend services to an applicant for the purpose of evaluating, diagnosing, or treating ~~alcohol or~~ substance use disorders that are: (5-8-09)()

a. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for treating the applicant's ~~alcohol or~~ substance use disorder; and (5-8-09)()

b. Not primarily for the convenience of the applicant or service provider and not more costly than an alternative service or sequence of services and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the applicant's ~~alcohol or~~ substance use disorder. (5-8-09)()

~~10. Clinical Team. A proposed client's clinical team may include: qualified clinicians, behavioral health professionals, professionals other than behavioral health professionals, behavioral health technicians and any other individual deemed appropriate and necessary to ensure that the assessment and subsequent treatment is comprehensive and meets the needs of the proposed client. (5-8-09)~~

~~11. Clinically Managed Low-Intensity Residential Treatment. Is a program that offers at least five (5) hours per week of outpatient or intensive outpatient treatment services along with a structured recovery environment, staffed twenty-four (24) hours per day, which provides sufficient stability to prevent or minimize relapse or continued use. This level of care is also known as a Halfway House. (5-8-09)~~

~~12. Clinically Managed Medium-Intensity Residential Treatment. Frequently referred to as residential care, programs provide a structured, twenty-four (24) hour intensive residential program for clients who require treatment services in a highly structured setting. This type of program is appropriate for clients who need concentrated, therapeutic services prior to community residence. Community reintegration of residents in this level of care requires case management activities directed toward networking clients into community-based recovery support services such as housing, vocational services or transportation assistance so that the client is able to attend mutual/self-help meetings or vocational activities after discharge. (5-8-09)~~

~~13. Comprehensive Assessment. Those procedures by which a substance use disorder clinician evaluates an individual's strengths, weaknesses, problems, needs, and determines priorities so that a service plan can be developed. (7-1-13)~~

~~14. Contracted Intermediary. A third-party contractor of the Department who handles direct contracting with network providers for treatment services to include network management, claims payment, data gathering per Federal and State requirements and census management. (5-8-09)~~

~~1508.~~ **Department.** The Idaho Department of Health and Welfare or ~~a person authorized to act on behalf of the Department~~ its designee. (5-8-09)()

~~16. Early Intervention Services. Services that are designed to explore and address problems or risk factors that appear to be related to substance use. (7-1-13)~~

~~17. Emergency. An emergency exists if an adult or adolescent individual is gravely disabled due to mental illness or substance abuse or dependence or there is a substantial risk that physical harm will be inflicted by the proposed client. (5-8-09)~~

~~a. Upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself; or (5-8-09)~~

~~b. Upon another person as evidenced by behavior which has caused such harm or which places~~

~~another person or persons in reasonable fear of sustaining such harm.~~

~~(5-8-09)~~

09. Eligibility Screening. The collection of data, analysis, and review, which the Department uses to screen and determine whether an applicant is eligible for adult or adolescent substance use disorder services available through the Department. ()

180. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: <http://aspe.hhs.gov/poverty/>. (5-8-09)

011. DEFINITIONS - G THROUGH Z.

For the purposes of these rules, the following terms are used as defined below:

(7-1-14)

01. Good Cause. ~~A valid and sufficient reason for not complying with the time frame set for submitting a written request for a waiver by an individual who does not receive a criminal history and background check clearance.~~ (7-1-14)

02. Gravely Disabled. ~~An adult or adolescent who, as a result of mental illness or substance abuse or dependence, is in danger of serious physical harm due to the person's inability to provide for any of his basic needs for nourishment, or essential medical care, or shelter or safety.~~ (5-8-09)

01. Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC). A board affiliated with the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC). The IBADCC is the certifying entity that oversees credentialing of Idaho Student of Addiction Studies (ISAS), and Certified Alcohol/Drug Counselors (CADC) in the state of Idaho. The IBADCC may be contacted at: PO Box 1548, Meridian, ID 83680; phone (208) 468-8802; Fax: (208) 466-7693; e-mail: IBADCC@ibadcc.org; <http://ibadcc.org/>. ()

02. Idaho Student of Addiction Studies (ISAS). An entry-level certification for substance use disorder treatment granted by the Idaho Board of Alcohol/Drug Counselor Certification. ()

03. Individualized Service Plan. A written action plan based on an ~~intake~~ eligibility screening and full clinical assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives and the criteria for terminating the specified interventions. (7-1-13)()

04. Intake Eligibility Screening. ~~The collection of data, analysis, and review, which the Department, or its designee, uses to screen and determine whether an applicant is eligible for adult or adolescent alcohol or substance use disorder services available through the Department.~~ (5-8-09)

054. Intensive Outpatient Services. ~~An organized service delivered by addiction professionals or addiction credentialed clinicians, which provides a planned regimen of treatment~~ Educational classes and individual or group counseling consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents. (5-8-09)()

06. Medically Monitored Detoxification. ~~Means medically supervised twenty-four (24) hour care for patients who require hospitalization for treatment of acute alcohol intoxication or withdrawal from one (1) or more other substances of abuse, and other medical conditions which together warrant treatment in this type of setting. Length of stay varies depending on the severity of the disease and withdrawal symptoms.~~ (7-1-13)

07. Medically Monitored Inpatient Treatment. ~~Medically supervised twenty-four (24) hour care for patients requiring hospitalization and treatment services. Medically monitored inpatient treatment provides treatment services and access to full range of services offered by the hospital.~~ (7-1-13)

05. Medication Assisted Treatment (MAT). MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. ()

086. Network Treatment Provider. A treatment provider who has ~~facility~~ approval through the

Department and is contracted with the Department's Management Service Contractor. A list of network providers can be found at the Department's website given in Section 005 of these rules. The list is also available by calling these telephone numbers: 1 (800) 922-3406; or dialing 211. (5-8-09)()

07. Northwest Indian Alcohol/Drug Specialist Certification Board. A board that represents the Native American Chemical Dependency programs in the state of Washington, Oregon, and Idaho and offers certification for chemical dependency counselors. Information regarding certification standards may be obtained at the website at <http://www.nwiadcb.com/NWIADCB/index.html>. ()

098. Opioid ~~Replacement Outpatient Services~~ Treatment Program. This ~~service~~ program is specifically offered to a ~~client~~ participant who has opioids as his substance use disorder. Services are offered under the guidelines of a federally accredited program. (7-1-13)()

109. Outpatient Services. ~~An organized non residential service, delivered in a variety of settings, in which addiction treatment personnel provide professionally directed evaluation and treatment for alcohol and substance use disorders. Educational classes and individual or group counseling consisting of regularly scheduled sessions within a structured program for up to eight (8) hours of treatment per week for adults and five (5) hours of treatment per week for adolescents.~~ (5-8-09)()

110. Priority Population. Priority populations are populations who receive services ahead of other persons and are determined yearly by the Department ~~based on federal regulations~~. A current list of the priority population is available from the Department. (7-1-13)()

121. Recovery Support Services. ~~Non clinical services designed to initiate, support, and enhance recovery.~~ These services ~~may~~ include: safe and sober housing that is staffed; transportation; child care; ~~family education~~; life skills education; ~~marriage education~~; drug testing; peer to peer mentoring; and case management. (5-8-09)()

13. Residential Social Detoxification. ~~Means a medically supported twenty four (24) hour, social rehabilitation residential program which provides physical care, education, and counseling as appropriate for the client's health and safety during his process of physical withdrawal from acute alcohol intoxication or withdrawal, or from one or more other substances of abuse. Social detoxification provides access into care and treatment of alcohol or substance use disorders through monitored withdrawal, evaluation of present or potential alcohol or substance dependency and other physical ailments, and intervention into the progression of the disease through timely utilization of resources. Length of stay in a social detoxification program varies from three (3) to seven (7) days depending on the severity of the disease and withdrawal symptoms.~~ (5-8-09)

14. Sliding Fee Scale. ~~A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules."~~ (5-8-09)

15. Substance Dependence. ~~Substance dependence is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol or other drugs despite significant related problems. The cluster of symptoms can include: tolerance; withdrawal or use of a substance in larger amounts or over a longer period of time than intended; persistent desire or unsuccessful efforts to cut down or control substance use; a great deal of time spent in activities related to obtaining or using substances or to recover from their effects; relinquishing important social, occupational or recreational activities because of substance use; and continuing alcohol or drug use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by such use as defined in the DSM-IV-TR.~~ (5-8-09)

12. Residential Treatment Services. A planned and structured regimen of treatment provided in a 24-hour residential setting. Residential programs serve individuals who, because of function limitations need safe and stable living environments and 24-hour care. ()

163. Substance-Related Disorders. Substance-related disorders include disorders related to the taking of alcohol or another ~~addictive~~ drug ~~of abuse~~, to the side effects of a medication, and to toxin exposures. They ~~are divided into two (2) groups: the~~ include ~~S~~substance ~~U~~use ~~D~~isorders, and ~~the S~~substance ~~Induced~~ intoxication, ~~substance withdrawal, and substance-induced D~~isorders as defined in the DSM-~~IV-TR~~5. (5-8-09)()

~~174. Substance Use Disorder. Includes Substance Dependence and Substance Abuse, according to the DSM-IV-TR. Substance Use Disorders are one (1) of two (2) subgroups of the broader diagnostic category of Substance-Related Disorders. A substance use disorder is evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. According to the DSM-5, diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance.~~ (5-8-09)()

~~18. Substantial Material Change in Circumstances. A substantial and material change in circumstances which renders the Department's decision denying alcohol and substance use disorders services arbitrary and capricious.~~ (5-8-09)

~~15. Withdrawal Management. Services necessary to monitor and manage the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.~~ ()

012. -- 099. (RESERVED)

PARTICIPANT ELIGIBILITY (Sections 100 - 199)

100. ACCESSING ~~ALCOHOL AND~~ SUBSTANCE USE DISORDERS SERVICES.

~~The Department's~~ Adult and adolescent ~~alcohol and~~ substance use disorders services may be accessed by eligible applicants ~~through~~ completing an application for services and ~~request for an intake~~ eligibility screening. (5-8-09)()

101. INTAKE ELIGIBILITY SCREENING AND ~~FULL~~ CLINICAL ASSESSMENT.

01. Intake Eligibility Screening. A screening for eligibility ~~for alcohol and~~ substance use disorders services through the Department is based on ~~meeting priority population and ASAM PPC-2R criteria as incorporated by reference in Section 004~~ the eligibility requirements under Section 102 of these rules. ~~If~~ When an applicant meets ~~this~~ eligibility screening criteria he may be eligible for ~~alcohol and~~ substance use disorders services through the Department. ~~An~~ applicants not meeting ~~this~~ eligibility screening criteria will be referred to other appropriate community services. ~~All~~ Each applicants ~~are~~ is required to complete an ~~A~~ application for ~~Alcohol and~~ Substance Use Disorders Services ~~either over the telephone or in person at a network treatment provider site.~~ ~~If~~ When an applicant refuses to complete the application, the Department reserves the right to discontinue the screening process for eligibility. The ~~intake~~ eligibility screening must be directly related to the applicant's ~~substance dependence or~~ substance-related disorder and level of functioning, and will include: (5-8-09)()

- a. Application for ~~Alcohol or~~ Substance Use Disorders Services; ~~pending document approval;~~ (5-8-09)()
- b. Notice of Privacy Practice; and (5-8-09)()
- ~~c.~~ Fee Determination; and (5-8-09)
- ~~d.~~ Authorization for Disclosure. (5-8-09)

02. Full Clinical Assessment. ~~If~~ When the applicant is found eligible for ~~alcohol and~~ a substance use disorders services assessment after completion of the ~~intake~~ eligibility screening, the applicant will ~~either be placed on a waiting list to receive a full clinical assessment or will have an appointment made~~ be authorized to receive a full clinical assessment with a Department's network treatment provider. (5-8-09)()

102. ELIGIBILITY DETERMINATION.

01. Determination of Eligibility for ~~Alcohol and~~ Substance Use Disorders Services. ~~The total number of adults and adolescents who are eligible for alcohol or substance use disorders services through the~~

~~Department will be established by the Department.~~ The Department may limit or prioritize adult and adolescent ~~alcohol or~~ substance use disorder services, impose income limits, define eligibility criteria, and establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. (7-1-13)()

02. Eligibility Requirements. To be eligible for ~~alcohol and~~ substance use disorders services through a voluntary application to the Department, the applicant must: (5-8-09)()

- a. Be an adult or adolescent with family income at or below two hundred percent (200%) of federal poverty guidelines; (5-8-09)
- b. Be a resident of the state of Idaho; (5-8-09)
- c. Be a member of ~~the a~~ priority population; (5-8-09)()
- d. Meet diagnostic criteria for ~~substance dependence, or~~ a substance-related disorder as described in the DSM-~~IV TR~~5; and (5-8-09)()
- e. Meet specifications in each of the ASAM ~~PPC-2R~~ dimensions required for the recommended level of care. (5-8-09)()

~~**03. Admission to Treatment Program Requirements.** In order to be admitted into an adult or adolescent alcohol or substance use disorders treatment program, there must be clinical evidence that provides a reasonable expectation that the applicant will benefit from the alcohol or substance use disorder services.~~ (5-8-09)

~~**04. Ineligible Conditions.** An applicant who has epilepsy, an intellectual disability, dementia, a developmental disability, physical disability, mental illness, or who is aged, is not eligible for alcohol and substance use disorders services, unless, in addition to such condition, they meet primary diagnostic criteria for substance abuse, substance dependence, or a substance related disorder as described in the DSM-IV TR and the specification in each of the ASAM PPC-2R dimensions required for the recommended level of care.~~ (5-8-09)

103. NOTICE OF CHANGES IN ELIGIBILITY FOR ~~ALCOHOL AND~~ SUBSTANCE USE DISORDERS SERVICES.

The Department may, upon ten (10) days' written notice, reduce, limit, suspend, or terminate eligibility for ~~alcohol or~~ substance use disorders services. (5-8-09)()

104. NOTICE OF DECISION ON ELIGIBILITY.

01. Notification of Eligibility Determination. Within two (2) business days of ~~a~~ receiving a completed ~~intake~~ eligibility screening ~~and risk or~~ assessment ~~for outpatient services, and one (1) business day for social detoxification and residential treatment services; or both,~~ the Department, ~~or its contracted intermediary,~~ will notify the applicant or the applicant's designated representative ~~in writing~~ of its eligibility determination. When the applicant is not eligible for services through the Department, the applicant or the applicant's designated representative will be notified in writing. The written notice will include: (5-8-09)()

- a. The applicant's name and identifying information; (5-8-09)
- b. A statement of the decision; (5-8-09)
- c. A concise statement of the reasons for the decision; and (5-8-09)
- d. The process for pursuing an administrative appeal regarding eligibility determinations. (5-8-09)

02. Right to Accept or Reject ~~Alcohol and~~ Substance Use Disorders Services. ~~If~~ When the Department, ~~or its contracted intermediary,~~ determines that an applicant is eligible for ~~alcohol and~~ substance use disorders services through the Department, an individual has the right to accept or reject ~~alcohol and~~ substance use disorders services offered by the Department, unless imposed by law or court order. (5-8-09)()

03. Reapplication for ~~Alcohol and~~ Substance Use Disorders Services. If the Department determines that an applicant is not eligible for ~~alcohol and~~ substance use disorders services through the Department, the applicant may reapply ~~after six (6) months or~~ at any time upon a showing of a ~~substantial material~~ change in circumstances. ~~Also, if the individual screened is found not to meet admission criteria, but is in need of other types of services, the Department, or its contracted intermediary, will refer the individual to an agency or department which provides the appropriate services needed.~~ (5-8-09)()

~~1065. -- 1419.~~ (RESERVED)

120. FINANCIAL RESPONSIBILITY FOR SUBSTANCE USE DISORDERS SERVICES.

An individual receiving substance use disorders services through the Department is responsible for paying for the services received. The financial responsibility for each service is based on the individual's ability to pay as determined in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." ()

~~121. -- 149.~~ (RESERVED)

150. SELECTION OF SERVICE PROVIDERS.

A participant who is eligible for substance use disorders services administered by the Department can choose a substance use disorders service provider from the approved list of Network Treatment Providers for services needed. Treatment services must be within the recommended level of care according to ASAM based on the individual's needs identified in the assessment and resulting individualized service plan. A participant within the criminal justice system may have a limited number of providers from which to choose. ()

~~151. -- 199.~~ (RESERVED)

~~200. INDIVIDUALIZED SERVICE PLAN, SELECTION OF SERVICE PROVIDERS AND AVAILABLE TREATMENT SERVICES.~~

~~The Department's contracted provider will prepare for every client an individualized service plan that addresses the alcohol or substance disorders health affects on the client's major life areas. The service plan will be based on a comprehensive assessment.~~ (7-1-13)

~~01. Individualized Service Plan. The responsibility for development and implementation of the plan will be assigned to a qualified staff member. A service plan will be developed within seventy-two (72) hours following admission to an inpatient or residential facility and within thirty (30) days of the completion or receipt of a state-approved assessment in an outpatient setting. The individualized service plan will include the following:~~ (7-1-13)

~~a. The services deemed clinically necessary to facilitate the client's alcohol and substance use disorders recovery;~~ (7-1-13)

~~b. Referrals for needed services not provided by the program, including referrals for recovery support services;~~ (7-1-13)

~~c. Goals to achieve a recovery-oriented lifestyle;~~ (7-1-13)

~~d. Objectives that relate to the goals, written in measurable terms, with targeted expected achievement dates;~~ (7-1-13)

~~e. Service Frequency;~~ (7-1-13)

~~f. Criteria to be met for discharge from services;~~ (7-1-13)

~~g. A plan for services to be provided after discharge;~~ (7-1-13)

~~h. A plan for including the family or other social supports; and~~ (7-1-13)

~~i. Service plan goals and objectives that reflect the service needs identified on the assessment.~~

(7-1-13)

~~02. Selection of Providers. The client can choose from among the array of substance use disorders treatment providers approved to provide services. The services must be within the recommended level of care according to ASAM PPC 2R and based on needs identified in the comprehensive assessment and resultant individualized service plan. The client does not have the option of choosing his treatment provider if he is within the criminal justice system and specific providers have been identified for the client.~~ (7-1-13)

~~03. Treatment Services Available. Available alcohol or substance use disorders treatment services, as defined in Section 010 of these rules, include:~~ (5-8-09)

- ~~a. Assessment and Referral services;~~ (7-1-13)
- ~~b. Residential social detoxification;~~ (7-1-13)
- ~~c. Medically monitored inpatient treatment;~~ (7-1-13)
- ~~d. Medically monitored detoxification;~~ (7-1-13)
- ~~e. Clinically managed medium intensity residential treatment;~~ (7-1-13)
- ~~f. Clinically managed low intensity residential treatment;~~ (5-8-09)
- ~~g. Level I Outpatient, and Level II Intensive Outpatient;~~ (7-1-13)
- ~~h. Opioid treatment program;~~ (7-1-13)
- ~~i. Recovery support services; and~~ (7-1-13)
- ~~j. Early intervention services.~~ (7-1-13)

~~04. Treatment Services Not Available. Alcohol or substance use disorder treatment services, do not include:~~ (5-8-09)

- ~~a. Experimental or investigational procedures;~~ (5-8-09)
- ~~b. Technologies and related services;~~ (5-8-09)
- ~~c. Electroconvulsive therapy;~~ (5-8-09)
- ~~d. Treatment or services for epilepsy, an intellectual disability, dementia, a developmental disability, physical disability, aged or the infirm; or~~ (5-8-09)
- ~~e. Any other services which are primarily recreational or diversional in nature.~~ (5-8-09)

~~201.—299. (RESERVED)~~

~~300. CHARGES FOR ALCOHOL AND SUBSTANCE USE DISORDERS SERVICES.~~

~~Individuals receiving alcohol and substance use disorders services through the Department are responsible for paying for the services provided. Individuals must complete a "Fee Determination Form," in writing or by telephone, prior to the delivery of alcohol and substance use disorders services. The amount charged for each service will be in accordance with the individual's ability to pay as determined in: IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," Section 500.~~ (5-8-09)

SUBSTANCE USE DISORDER SERVICES
(Sections 200 - 600)

200. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL PERSONNEL REQUIRED.

Each behavioral health program providing substance use disorders services must employ the number and variety of staff needed to provide the services and treatments offered by the program as a multidisciplinary team. The program must employ at least one (1) qualified substance use disorders professional for each behavioral health program location. ()

01. Qualified Substance Use Disorders Professional. A qualified substance use disorders professional includes individuals with the following qualifications: ()

a. Idaho Board of Alcohol/Drug Counselor Certification - Certified Alcohol/Drug Counselor; ()

b. Idaho Board of Alcohol/Drug Counselor Certification - Advanced Certified Alcohol/Drug Counselor; ()

c. Northwest Indian Alcohol/Drug Specialist Certification - Counselor II or Counselor III; ()

d. National Board for Certified Counselors (NBCC) - Master Addictions Counselor (MAC); ()

e. “Licensed Clinical Social Worker” (LCSW) or a “Licensed Masters Social Worker” (LMSW) licensed under Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, “Rules of the State Board of Social Work Examiners”; ()

f. “Marriage and Family Therapist” or “Associate Marriage and Family Therapist,” licensed under Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, “Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists”; ()

g. “Nurse Practitioner” licensed under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing”; ()

h. “Clinical Nurse Specialist” licensed under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing”; ()

i. “Physician Assistant” licensed under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, “Rules for the Licensure of Physician Assistants”; ()

j. “Licensed Professional Counselor” (LPC) or a “Licensed Clinical Professional Counselor” (LCPC) licensed under Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, “Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists”; ()

k. “Psychologist” or “Psychologist Extender” licensed under Title 54, Chapter 23, Idaho Code, and IDAPA 24.12.01, “Rules of the Idaho State Board of Psychologist Examiners”; ()

l. “Physician” licensed under Title 54, Chapter 18, Idaho Code; and ()

m. “Registered Nurse (RN)” licensed under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, “Rules of the Idaho Board of Nursing.” ()

02. Qualified Substance Use Disorders Professional Prior to May 1, 2010. When an individual was recognized by the Department as a qualified professional in a substance use disorders services program prior to May 1, 2010, and met the requirements at that time, he will continue to be recognized by the Department as a qualified substance use disorders professional. ()

201. -- 209. (RESERVED)

210. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL TRAINEE.

Each qualified substance use disorders professional trainee practicing in the provision of substance use disorders services must meet the requirements in these rules. ()

01. Informed of Qualified Substance Use Disorders Professional Trainee Providing Treatment.

All behavioral health program staff, participants, their families, or guardians must be informed when a qualified substance use disorders professional trainee is providing treatment services to participants. ()

02. Work Qualifications for Qualified Substance Use Disorders Professional Trainee. A qualified substance use disorders professional trainee must meet one (1) of the following qualification to begin work: ()

- a.** Idaho Student in Addiction Studies (ISAS) certification; ()
- b.** Formal documentation as a Northwest Indian Alcohol/Drug Specialist Counselor I; or ()
- c.** Formal documentation of current enrollment in a program for qualifications in Section 200 of these rules. ()

03. Continue as Qualified Substance Use Disorders Professional Trainee. An individual who has completed a program listed in Section 200 of these rules and is awaiting licensure can continue as a qualified substance use disorders professional trainee at the same agency for a period of six (6) months from the date of program completion. ()

211. -- 299. (RESERVED)

300. SERVICES FOR ADOLESCENTS.

Behavioral health programs providing substance use disorders treatment to adolescents must comply with the following requirements: ()

01. Separate Services From Adults. Each program providing adolescent program services must provide the services separate from adult program services. The program must ensure the separation of adolescent participants from adult participants except as required in Subsections 300.03 and 300.04 of this rule. ()

02. Residential Care as an Alternative to Parental Care. Any program that provides care, control, supervision, or maintenance of adolescents for twenty-four (24) hours per day as an alternative to parental care must meet the following criteria: ()

- a.** Be licensed under the "Child Care Licensing Act," Title 39, Chapter 12, Idaho Code, according to IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing"; or ()
- b.** Be certified by the Department of Juvenile Corrections according to IDAPA 05.01.02, "Rules and Standards for Secure Juvenile Detention Centers." ()

03. Continued Care of an Eighteen-Year-Old. An adolescent who turns the age of eighteen (18), and is receiving outpatient or intensive outpatient treatment in a state-approved behavioral health program, may remain in the program under continued care described in Subsection 300.03 of this rule. The individual may remain in the program for: ()

- a.** Up to ninety (90) days after his eighteenth birthday; or ()
- b.** Until the close of the current school year for an individual attending school. ()

04. Documentation Requirements for Continued Care. Prior to accepting an individual into continued care, the program must assure and document the following: ()

- a.** A signed voluntary agreement to remain in the program or a copy of a court order authorizing continued placement after the individual's eighteenth birthday. ()

- b. Clinical staffing for appropriateness of continued care with clinical documentation; ()
- c. Verification the individual in continued care was in the care of the program prior to his eighteenth birthday. ()
- d. Verification that the individual needs to remain in continued care in order to complete treatment, education, or other similar needs. ()

05. Licensed Hospital Facilities. Facilities licensed as hospitals under Title 39, Chapter 13, Idaho Code, are exempt from the requirements in Subsections 300.01 through 300.04 of this rule. ()

301. -- 349. (RESERVED)

350. RECOVERY SUPPORT SERVICES.

Each program must meet the minimum requirements in these rules to provide recovery support services for the following services. ()

- 01. Case Management. ()
- 02. Alcohol and Drug Screening. ()
- 03. Child Care. ()
- 04. Transportation. ()
- 05. Life Skills. ()
- 06. Staffed Safe and Sober Housing for Adolescents. ()
- 07. Staffed Safe and Sober Housing for Adults. ()

351. -- 354. (RESERVED)

355. CASE MANAGEMENT SERVICES.

Each program providing case management services must comply with the requirements in this rule. ()

- 01. No Duplication of Services. Case management services must not duplicate services currently provided under another program. ()
- 02. Based on Assessment. Case management services must be based on an assessment of participant's needs. ()
- 03. Required Service Plan. Case management services must be included on the participant's service plan. ()

356. -- 359. (RESERVED)

360. ALCOHOL AND DRUG SCREENING.

Each program providing alcohol and drug screenings must comply with the requirements in this rule. ()

- 01. Drug Testing Policies and Procedures. The program must have policies and procedures regarding the collection, handling, testing, and reporting of drug-testing specimens. Policies and procedures must include elements contributing to the reliability and validity of the screening and testing process. ()
- a. Direct observation of specimen collection; ()

b. Verification temperature and measurement of creatinine levels in urine samples to determine the extent of water loading; ()

c. Specific, detailed, written procedures regarding all aspects of specimen collection, specimen evaluation, and result reporting; ()

d. A documented chain of custody for each specimen collected; ()

e. Quality control and quality assurance procedures for ensuring the integrity of the process; and ()

f. Procedures for verifying accuracy when drug test results are contested. ()

02. Release of Results. The program must have a policy and procedures for releasing the results of an alcohol and drug screening. ()

03. On-site Testing. A program performing on-site testing must use alcohol and drug screening tests approved by the U.S. Food and Drug Administration. ()

04. Laboratory Used for Testing. Each laboratory used for lab-based confirmation or lab-based testing must meet the requirements in and be approved under IDAPA 16.02.06, "Rules Governing Quality Assurance for Idaho Clinical Laboratories." ()

361. -- 364. (RESERVED)

365. CHILD CARE SERVICES. Each program providing child care services must comply with the requirements in this rule. ()

01. Documentation of Child Care. A program must maintain documentation of current daycare license or written documentation that child care is provided while parent is on-site. ()

02. Policies and Procedures for Child Care Services. The program must have policies and procedures that ensure the well-being and safety of children receiving child care services. ()

366. -- 369. (RESERVED)

370. TRANSPORTATION SERVICES. Each program providing transportation services must comply with the requirements in this rule. ()

01. Documentation of Driver's License. A program that provides transportation to participants must maintain documentation of a valid driver's license for each individual who provides the service. ()

02. Transportation Vehicles and Drivers. A program must adhere to all state and federal laws, rules, and regulations applicable to drivers and types of vehicles used. ()

03. Insurance Liability Coverage. A behavioral health provider must carry at least the minimum insurance coverage required by Idaho law for each vehicle used. When the program permits an employee to transport participants in an employee's personal vehicle, the program must ensure that insurance coverage is carried to cover those services. ()

04. Direct Routes. A program must provide transportation by the most direct route practical. ()

05. Safety of Participants. A program must ensure the safety and well-being of all participants transported. This includes maintaining and operating vehicles in a manner that ensures protection of the health and safety of each participant transported. The program must meet the following requirements: ()

a. Prohibit the driver from using a cell phone while transporting a participant; ()

b. Prohibit smoking in the vehicle; ()

c. All vehicles must be equipped with a first aid kit and fire extinguisher; ()

d. All vehicles must be equipped with appropriate safety restraints; and ()

e. All vehicles must be in good working order. ()

06. **Driver Must be Eighteen.** The driver of a motor vehicle who transports program participants must be at least eighteen (18) years of age. ()

371. -- 374. (RESERVED)

375. LIFE SKILLS SERVICES.

Each program that provides life skills services must comply with the requirements in this rule. ()

01. Personal and Family Life Skills. A program for life skills services must be non-clinical and designed to enhance personal and family skills for each participant's needs. Life skills services for work and home, reduce marriage and family conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community for the participant. ()

02. Individual and Group Activities. A program providing life skills services may be provided on an individual basis or in a group setting and can include activities that are culturally, spiritually, or gender-specific. ()

03. No Duplication of Services. Life skills services provided by a program must not duplicate services currently provided under another program. ()

376. -- 379. (RESERVED)

380. STAFFED SAFE AND SOBER HOUSING FOR ADOLESCENTS.

Each program that provides staffed safe and sober housing for adolescents must comply with the requirements in this rule. ()

01. Licensed. A program providing staffed safe and sober housing services for adolescents must be licensed as a Children's Residential Care Facility under IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." ()

02. Policies and Procedures. A program providing safe and sober housing for adolescents must have written policies and procedures that establish house rules and requirements and include procedures for monitoring participant compliance and consequences for violating house rules and requirements. ()

03. Safe and Sober Recovery Skills. Safe and sober housing services are directed toward applying recovery skills, preventing relapse, improving social functioning and ability for self-care, promoting personal responsibility, developing a social network supportive of recovery, and reintegrating the each adolescent into the worlds of school, work, family life, and preparing for independent living. ()

381. -- 384. (RESERVED)

385. STAFFED SAFE AND SOBER HOUSING SERVICES FOR ADULTS.

Each program that provides staffed safe and sober housing for adults must comply with the requirements in this rule. ()

01. Policies and Procedures. A program providing safe and sober housing must have written policies and procedures that establish house rules and requirements and include procedures for monitoring participant compliance and consequences for violating house rules and requirements. ()

02. Staff Required. A staff person must be available to residents twenty-four (24) hours per day, seven (7) days a week, and conduct daily site visits: At a minimum, staff must include: ()

a. A house manager who is on-site at a minimum of twenty (20) hours a week; or ()

b. A housing coordinator who is off-site, but monitors house activities on a daily basis. ()

03. Certified Home Inspection. Each staffed safe and sober housing for adults program must have a certified home inspection for each location. There must be documentation that any major health and safety issues identified in the certified home inspection are corrected. ()

04. Safety Inspection. Each staffed safe and sober housing location must be inspected weekly by staff to determine if hazards or potential safety issues exist. A record of the inspection must be maintained that includes the date and time of the inspection, problems encountered, and recommendation for improvement. ()

386. -- 389. (RESERVED)

390. THERAPEUTIC ENVIRONMENT OF RESIDENTIAL TREATMENT.

Each program providing twenty-four (24) hours per day residential treatment must provide a therapeutic environment that enhances the participants positive self-image, preserves their human dignity, and meets the minimum standards in these rules. ()

01. Living Conditions. A residential treatment program must meet the following requirements regarding each participant's therapeutic environment: ()

a. Each participant must be allowed to wear his own clothing. If clothing is provided by the program, it must be appropriate and not demeaning. ()

b. Each participant must be allowed to keep and display personal belongings, and to add personal touches to the decoration of own room. ()

c. A residential treatment program must have policies and procedures for storage, availability, and use of personal possessions, personal hygiene items, and other belongings. ()

d. The residential treatment program must have ample closet and drawer space for the storage of personal property and property provided for each participant's use. ()

02. Resident Sleeping Rooms. A residential treatment program must assure that: ()

a. Resident sleeping rooms are not in attics, stairs, halls, or any other room commonly used for other than bedroom purposes: ()

b. Sufficient window space must be provided for natural light and ventilation. Emergency egress or rescue windows must comply with the state-adopted Uniform Building Code. This code is available from the International Code Council, 4051 West Fossmoor Rd. Country Club Hills, IL 60478-5795, phone: 1-888-422-7233 and online at <http://www.iccsafe.org>; ()

c. Square footage requirements for resident sleeping rooms must provide at least seventy (70) square feet, exclusive of closet space, in a single occupancy room. In a multiple occupancy room, there must be at least forty-five (45) square feet per occupant, exclusive of closet space. Existing multiple occupancy sleeping rooms may be approved relative to square feet per occupant until the room is remodeled or the building is extensively remodeled. ()

d. Window screens must be provided on operable windows: ()

e. Doorways to sleeping areas must be provided with doors in order to provide privacy; and ()

f. Separate bedrooms and bathrooms must be provided for men and women. ()

03. Contributions of Therapeutic Environment. The environment of the residential treatment program must contribute to the development of therapeutic relationships in the following ways: ()

a. Areas must be available for a full range of social activities for all participants, from two (2) person conversations to group activities: ()

b. Furniture and furnishings must be comfortable and maintained in clean condition and good repair: and ()

c. All equipment and appliances must be maintained in good operating order. ()

391. -- 394. (RESERVED)

395. RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES.

Each program providing substance use disorders residential withdrawal management services must comply with the requirements in this rule. ()

01. Residential Withdrawal Management Services. ()

a. Residential withdrawal management programs must provide living accommodations in a structured environment for individuals who require twenty-four (24) hour per day, seven (7) days a week, supervised withdrawal management services. ()

b. Withdrawal management services must be available continuously twenty-four (24) hours per day, seven (7) days per week. ()

c. Each withdrawal management program must have clear written policies and procedures for the withdrawal management of participants. The policies and procedures must be reviewed and approved by a medical consultant with specific knowledge of best practices for withdrawal management. ()

d. The level of monitoring of each participant or the physical restrictions of the environment must be adequate to prevent a participant from causing serious harm to self or others. ()

e. Each withdrawal management program must have provisions for any emergency care required. ()

f. Each withdrawal management program must have written policies and procedures for the transfer of participants from one (1) withdrawal management program to another, when necessary. ()

g. Each withdrawal management program must have written policies and procedures for dealing with a participant who leaves against professional advice. ()

02. Residential Withdrawal Management Staffing. Each withdrawal management program must have twenty-four (24) hour per day, seven (7) days a week, trained personnel staff coverage. ()

a. A minimum staff to participant ratio of one (1) trained staff to six (6) participants must be maintained twenty-four (24) hours per day, seven (7) days a week. ()

b. Each staff member responsible for direct care during withdrawal management must have completed CPR training, a basic first-aid training course, and additional training specific to withdrawal management prior to being charged with the responsibility of supervising participants. ()

03. Transfer to an Outside Program From Residential Withdrawal Management. The residential treatment program must have policies and procedures established for transferring a participant to another program. ()

()

396. -- 399. (RESERVED)

400. RESIDENTIAL TREATMENT SERVICES FOR ADOLESCENTS.

A behavioral health program providing adolescent residential treatment for substance use disorders must comply with the requirements in this rule. ()

01. Licensed for Adolescent Residential Treatment. Each residential treatment program must be licensed as a Children's Residential Care Facility under IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing." ()

02. Admission Criteria for Adolescent Residential Treatment. A behavioral health program providing adolescent residential treatment for substance use disorders must only admit adolescents with a primary substance use disorder diagnosis. ()

03. Focus of Adolescent Residential Treatment Services. Adolescent residential treatment services for substance use disorders must focus primarily on substance use disorders diagnosed problems. Care must include hours specific to substance use disorders treatment provided by clinical staff, including planned and structured education, individual and group counseling, family counseling, and motivational counseling. An adolescent residential treatment program must provide: ()

a. Individual and group counseling sessions; ()

b. Family treatment services; and ()

c. Substance use disorders education sessions; ()

04. Staff Training in Adolescent Residential. Annual staff training must include: ()

a. Cultural sensitivity and diversity; ()

b. Behavior management; and ()

c. Adolescent development issues appropriate to the population served. ()

05. Residential Care Provided to Adolescents and Adults. A behavioral health program providing residential treatment services to adolescents and adults must ensure the separation of adolescent participants from adult participants. This includes not sharing the same wing, or the same floor for recreation, living, sleeping, and restroom facilities. Adolescents must not dine with adult residents. Adolescents must not share treatment groups, recreation, counseling sessions, educational programs, or treatment programs with adults except under continued care in compliance with IDAPA 16.06.02, "Rules Governing Standards for Child Care Licensing," and Subsections 300.03 and 300.04 of these rules. ()

06. After Care Plan for Adolescent in Residential. An adolescent's residential care facility that provides substance use disorders treatment must develop a written plan of after care services for each adolescent that includes procedures for reintegrating the adolescent into the family and community as appropriate, and outpatient and other continued care services recommended. ()

401. -- 404. (RESERVED)

405. RESIDENTIAL TREATMENT SERVICES FOR ADULTS.

A behavioral health program providing adult residential treatment for substance use disorders must comply with the requirements in this section. ()

01. Residential Treatment Services for Adults. ()

a. A residential treatment program provides living accommodations in a structured environment for adults who require twenty-four (24) hour per day, seven (7) days a week, supervision. ()

b. Services must include assessment, treatment, and referral components. ()

c. The residential treatment program must have policies and procedures for medical screening, care of participants requiring minor treatment or first aid, and handling of medical emergencies. These provisions must be approved by the staff and consulting physician. ()

d. The residential treatment program must have written provisions for referral or transfer to a medical facility for any person who requires nursing or medical care. ()

e. Recreational activities must be provided for the participants. ()

02. Staffing Adult Residential. The residential treatment program must have must have qualified staff to maintain appropriate staff to participant ratios. ()

a. The program must have one (1) qualified substance use disorders professional staff member for every ten (10) participants. ()

b. The program must have other staff sufficient to meet the ratio of one (1) staff person to twelve (12) participants continuously, twenty-four (24) hours per day. ()

03. Residential Care Provided to Adolescents and Adults. A behavioral health program providing residential care to adolescents and adults must ensure the separation of adolescent participants from adult participants. Adults and adolescents can not share the same wing, or the same floor for recreation, living, sleeping, and restroom facilities. Adolescents must not dine with adult residents. Adolescents must not share treatment groups, recreation, counseling sessions, educational programs, or treatment programs with adults unless there is a documented therapeutic reason. ()

406. -- 409. (RESERVED)

410. OUTPATIENT TREATMENT SERVICES FOR ADOLESCENTS AND ADULTS.

A behavioral health program providing outpatient or intensive outpatient substance use disorder services must comply with the requirements in this section. ()

01. Treatment Services. ()

a. Counseling services must be provided through the outpatient program on an individual, family, or group basis; ()

b. Services must include educational instruction and written materials on the nature and effects of alcohol and substance use disorders and the recovery process. ()

c. The behavioral health program must provide adjunct services or refer the participant to adjunct services as indicated by participant need. ()

02. Staffing Ratios. The behavioral health program must have qualified staff to maintain appropriate staff to participant ratios as required in Subsections 410.02.a. through 410.02.c. of this rule. ()

a. An outpatient program must employ at a minimum one (1) qualified substance use disorders professional staff person for every fifty (50) participants. ()

b. An intensive outpatient program must employ at a minimum one (1) qualified substance use disorders professional staff person for every thirty (30) participants. ()

c. The maximum caseload for one (1) qualified substance use disorders professional in any outpatient

or intensive outpatient program is fifty (50) participants. ()

03. Off-site Treatment Service Delivery Settings. Provision of outpatient or intensive outpatient treatment services outside of an approved behavioral health program location: ()

a. Services must be provided by qualified substance use disorders professional. ()

b. Services must be provided in a setting that is safe and appropriate to the participant and participant's needs. ()

c. Confidentiality according to 42 CFR and HIPAA regulations must be adhered to. ()

d. The need and appropriateness of providing off-site treatment is documented. ()

411. -- 414. (RESERVED)

415. MEDICATION ASSISTED TREATMENT.

01. Medication Assisted Treatment Services. A behavioral health program providing medication assisted treatment for substance use disorders must make counseling and behavioral therapies available in combination with medication assisted treatment services. ()

02. Opioid Treatment Program. An Opioid Treatment Program (OTP) must meet all requirements established under 42 CFR, Section 8.12, Federal Opioid Treatment Standards. These standards are incorporated by reference under Section 004 of these rules including how access the standards. ()

~~304~~**16. -- 999. (RESERVED)**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.07.20 - ALCOHOL AND SUBSTANCE USE DISORDERS TREATMENT
AND RECOVERY SUPPORT SERVICES FACILITIES AND PROGRAMS

DOCKET NO. 16-0720-1501 (CHAPTER REPEAL)

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. In accordance with Section 67-5224(5)(a) and (b), Idaho Code, as specified here in this notice the pending rule becomes final and effective on July 1, 2016, after review by the legislature, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is affected by concurrent resolution, the concurrent resolution shall specify the date.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. This action is authorized pursuant to Title 39, Chapter 3, and Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

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

The Department is integrating services to better match current practices for behavioral health and mental health services. There are no changes to the pending rule and it is being adopted as originally proposed to repeal the entire chapter. The Notice Of Repeal of the entire chapter published in the September 2, 2015, Idaho Administrative Bulletin, [Vol. 15-9, page 201](#).

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

This rulemaking has no fiscal impact to the state general fund, or any other funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 25th Day of November, 2015.

Tamara Prisock
DHW - Administrative Rules Unit
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 39, Chapter 3, and Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2015.

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

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

This chapter of rules is being repealed in its entirety. The Department is integrating services to better match current practices for substance use disorders and mental health services. This repealed chapter will be replaced with a new chapter in IDAPA 16.07.15, "Behavioral Health Programs," publishing simultaneously in this Bulletin under Docket Number 16-0715-1501.

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

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

This rulemaking has no fiscal impact to the state general fund, or any other funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 6, 2015, Idaho Administrative Bulletin, [Vol.15-5, pages 62-63](#) under Docket No. 16-0720-1501. The Department held three meetings around the state and also allowed participants to conference call into the meetings.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

CONTACT INFORMATION, WEB ADDRESS, ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at (208) 334-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2015.

DATED this 7th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0720-1501

IDAPA 16.07.20 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 22 - IDAHO STATE BOARD OF MEDICINE

22.01.01 - RULES OF THE BOARD OF MEDICINE FOR THE LICENSURE TO PRACTICE MEDICINE AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY IN IDAHO

DOCKET NO. 22-0101-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and full force and effect upon adoption of the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1806(2), 54-1806(4), (11), 54-1806A, 54-1812, 54-1813, 54-1814 and 54-1841, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2015 Idaho Administrative Bulletin, [Vol. 15-9, pages 227-229](#).

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: The proposed rule change is budget neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Anne K. Lawler, Executive Director, (208) 327-7000.

DATED this 24th day of November, 2015.

Anne K. Lawler, JD, RN
Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Suite 140
PO Box 83720
Boise, ID 83720-0058
Phone (208) 327-7000 / Fax (208) 327-7005

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized Pursuant to Sections 54-1806(2), 54-1806(4), (11), 54-1806A, 54-1812, 54-1813, 54-1814 and 54-1841, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2015.

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

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

The rule change allows international graduates enrolled in Idaho residency programs the opportunity to apply for full licensure after completing two years of residency training with the approval of the director of the Idaho residency program.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year resulting from this rulemaking: The proposed rule change is budget neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because in early 2015 interested parties approached the Board to request this rule change and in a negotiated process with interested parties this rule was drafted and vetted with the interested and participating parties.

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: Not applicable.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Anne K. Lawler, Executive Director, (208) 327-7000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2015.

DATED this 28th Day of August, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0101-1501

051. LICENSURE FOR GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS LOCATED OUTSIDE OF THE UNITED STATES AND CANADA.

01. International Medical Graduate. In addition to meeting the requirements of Section 050, graduates of international medical schools located outside of the United States and Canada must submit to the Board: (3-26-08)

a. Original certificate from the ECFMG or original documentation that the applicant has passed the examination either administered or recognized by the ECFMG and passed an examination acceptable to the Board that demonstrates qualification for licensure or successfully completed the United States Medical Licensing Exam (USMLE). (5-8-09)

b. Original documentation directly from the international medical school that establishes to the satisfaction of the Board that the international medical school meets the standards for medical educational facilities set forth in Subsection 051.02, and that both the scope and content of the applicant's coursework and performance were equivalent to those required of students of medical schools accredited by the LCME; (3-26-08)

c. Original documentation directly from the international medical school that it has not been disapproved or has its authorization, accreditation, certification or approval denied or removed by any state, country or territorial jurisdiction and that to its knowledge no state of the United States or any country or territorial jurisdiction has refused to license its graduates on the grounds that the school fails to meet reasonable standards for medical education facilities; (3-26-08)

d. A complete and original transcript from the international medical school showing successful completion of all the courses taken and grades received and original documentation of successful completion of all clinical coursework; and (3-26-08)

e. Original documentation of successful completion of three (3) years of progressive postgraduate training at one (1) training program accredited for internship, residency, or fellowship training by the ACGME, AOA or the Royal College of Physicians and Surgeons of Canada; provided however, a resident who is attending an Idaho based residency program may be licensed after successful completion of two (2) years of progressive post graduate training, if the following conditions are met: ~~(3-26-08)~~ ()

i. The resident must have the written approval of the residency program director; ()

ii. The resident must have a signed written contract with the Idaho residency program to complete the entire residency program; ()

iii. The resident must remain in good standing at the Idaho-based residency program; ()

iv. The residency program must notify the Board within thirty (30) days if there is a change in circumstances or affiliation with the program (for example, if the resident resigns or does not demonstrate continued satisfactory clinical progress); and ()

v. The Idaho residency program and the Idaho Board have prescreened the applicant to ensure that the applicant has received an MD or DO degree from an approved school that is eligible for Idaho licensure after graduation. ()

f. ECFMG. The certificate from the ECFMG is not required if the applicant holds a license to practice medicine which was issued prior to 1958 in one (1) of the states of the United States and which was obtained by written examination. (3-26-08)

02. International Medical School Requirements. (3-26-08)

a. An international medical school, as listed in the World Health Organization Directory of Medical Schools, which issued its first doctor of medicine degree less than fifteen (15) years prior to an application for licensure, must provide documented evidence of degree equivalency acceptable to the Board including, but not limited to: (3-26-08)

i. The doctor of medicine degrees issued must be substantially equivalent to the degrees issued by acceptable medical schools located within the United States or Canada. Equivalency shall be demonstrated, in part, by original documentation of a medical curriculum of not less than thirty-two (32) months, or its equivalent, of full-time classroom instruction and supervised clinical coursework. Such clinical coursework shall be in a hospital or hospitals that, at the time of the applicant's coursework, documented its evaluation of the applicant's performance in writing as a basis for academic credit by the medical school; (3-26-08)

ii. The medical school's admission requirements, including undergraduate academic subject requirements, entrance examination scores, and core curriculum are substantially equivalent to medical schools located within the United States or Canada; (3-26-08)

iii. The medical school has adequate learning facilities, class attendance, medical instruction, and clinical rotations consistent with quality medical education. (3-26-08)

iv. The medical school has not been disapproved or has its authorization, accreditation, certification,

licensure, or approval denied or removed by any state, country or territorial jurisdiction; and (3-26-08)

v. The medical school does not issue diplomas, confer degrees or allow graduation based on Internet or on-line courses inconsistent with quality medical education. (3-26-08)

b. An international medical school, as listed in the World Health Organization Directory of Medical Schools, which issued its first doctor of medicine degree more than fifteen (15) years prior to an application for licensure, may, in the Board's discretion, be required to provide original documented evidence of degree equivalency acceptable to the Board. (3-26-08)

IDAPA 22 - IDAHO STATE BOARD OF MEDICINE
22.01.15 - RULES RELATING TO TELEHEALTH SERVICES
DOCKET NO. 22-0115-1501 (NEW CHAPTER)
NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and full force and effect upon adoption of the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 54-1806(2), 54-1806(4), (11), 54-1806A, 54-1812, 54-1813, 54-1814 and 54-1841, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2015 Idaho Administrative Bulletin, [Vol. 15-9, pages 230–233](#).

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars (\$10,000) during the fiscal year: The proposed rule change is budget neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Anne K. Lawler, Executive Director, (208) 327-7000.

DATED this 24th Day of November, 2015.

Anne K. Lawler, JD, RN
Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Suite 140
PO Box 83720
Boise, ID 83720-0058
Phone (208) 327-7000 / Fax (208) 327-7005

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-5613 and Section 54-1806(2) Idaho Code.

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

Tuesday, September 15, 2015 - 12:00 P.M. (MDT)

Idaho State Board of Medicine
1755 Westgate Drive, Suite 140
Boise, Idaho 83704

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:

Passage of the Telehealth Access Act provides for the licensing boards to promulgate rules specific for the licensees that they regulate. The rules clarify the obligations of the licensed health care provider in providing telehealth services to Idaho citizens.

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

No fees are assessed by this rule.

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:

Not applicable. This rule is budget neutral and there is no fiscal impact to the general fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rules were drafted in conjunction with the Idaho Telehealth Council, Idaho Medical Association, Idaho Hospital Association, and other interested parties and comments and corrections were incorporated into this rule.

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

The Idaho Telehealth Access Act, Chapter 56, Title 54, Idaho Code is incorporated by reference into these rules as the guiding statute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Anne K. Lawler, Executive Director, (208) 327-7000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2015.

DATED this 28th Day of August 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0115-1501

IDAPA 22
TITLE 01
CHAPTER 15

22.01.15 - RULES RELATING TO TELEHEALTH SERVICES

000. LEGAL AUTHORITY.

Pursuant to Section 54-5713 and Section 54-1806(2), Idaho Code, the Idaho State Board of Medicine is authorized to promulgate rules relating to telehealth services. ()

001. TITLE AND SCOPE.

01. Title. These rules shall be cited as IDAPA 22.01.15, "Rules Relating to Telehealth Services." ()

02. Scope. These rules define the scope of practice for telehealth service providers and defines how the patient-provider relationship may be established without face-to-face, in-person contact and places limitations on the prescriptions that can be authorized via telehealth tools. ()

002. WRITTEN INTERPRETATIONS.

Written interpretations of these rules in the form of explanatory comments accompanying the notice of proposed rulemaking that originally proposed the rules and review of comments submitted in the rulemaking process in the adoption of these rules are available for review and copying at cost from the Board, 1755 Westgate Drive, Suite 140, Box 83720 Boise, Idaho 83720-0058. ()

003. ADMINISTRATIVE APPEAL.

All contested cases shall be governed by the provisions of IDAPA 04.11.01, "Idaho Rules of Administrative Procedures of the Attorney General," and this chapter. ()

004. PUBLIC RECORD ACT COMPLIANCE.

These rules have been promulgated according to the provisions of Title 67, Chapter 52, Idaho Code, and are public records. ()

005. INCORPORATION BY REFERENCE.

The Idaho Telehealth Access Act, Chapter 57, Title 54, Idaho Code, is incorporated by reference into these rules. ()

006. OFFICE -- OFFICE HOURS -- MAILING ADDRESS AND STREET ADDRESS.

The central office of the Board shall be in Boise, Idaho. The Board's mailing address, unless otherwise indicated, shall be Idaho State Board of Medicine, Statehouse Mail, Boise, Idaho 83720. The Board's street address is 1755 Westgate Drive, Suite 140, Boise, Idaho 83704. The telephone number of the Board is (208) 327-7000. The Board's facsimile (FAX) number is (208) 327-7005. The Board's website is www.bom.idaho.gov. The Board's office hours for filing documents are 8:00 a.m. to 5:00 p.m. MST. ()

007. FILING OF DOCUMENTS -- NUMBER OF COPIES.

All documents in rulemaking or contested case proceedings must be filed with the office of the Board. The original and one (1) electronic copy of all documents must be filed with the office of the Board. ()

008. -- 009. (RESERVED)

010. DEFINITIONS.

01. Board. The Idaho State Board of Medicine. ()

02. Referenced Definitions. The other definitions applicable to these rules are those definitions set forth in the Idaho Telehealth Access Act and in Section 54-5703, Idaho Code. ()

011. IDAHO LICENSE REQUIRED.

Any physician, physician's assistant, respiratory therapist, polysomnographer, dietician, or athletic trainer who provides any telehealth services to patients located in Idaho must hold an active Idaho license issued by the Idaho State Board of Medicine for their applicable practice. ()

012. PROVIDER-PATIENT RELATIONSHIP.

In addition to the requirements set forth in Section 54-5705, Idaho Code, during the first contact with the patient, a provider licensed by the Idaho State Board of Medicine who is providing telehealth services shall: ()

01. Verification. Verify the location and identity of the patient; ()

02. Disclose. Disclose to the patient the provider's identity, their current location and telephone number and Idaho license number; ()

03. Consent. Obtain appropriate consents from the patient after disclosures regarding the delivery models and treatment methods or limitations, including a special informed consent regarding the use of telehealth technologies; and ()

04. Provider Selection. Allow the patient an opportunity to select their provider rather than being assigned a provider at random to the extent possible. ()

013. STANDARD OF CARE.

A provider providing telehealth services to patients located in Idaho must comply with the applicable Idaho community standard of care. The provider shall be personally responsible to familiarize themselves with the applicable Idaho community standard of care. If a patient's presenting symptoms and conditions require a physical examination, lab work or imaging studies in order to make a diagnosis, the provider shall not provide diagnosis or treatment through telehealth services unless or until such information is obtained. ()

014. INFORMED CONSENT.

In addition to the requirements of Section 54-5708, Idaho Code, evidence documenting appropriate patient informed consent for the use of telehealth technologies must be obtained and maintained at regular intervals consistent with the community standard of care. Appropriate informed consent should, at a minimum, include the following terms: ()

01. Verification. Identification of the patient, the provider and the provider's credentials; ()

02. Telehealth Determination. Agreement of the patient that the provider will determine whether or not the condition being diagnosed and/or treated is appropriate for telehealth services; ()

03. Security Measures Information. Information on the security measures taken with the use of telehealth technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy and notwithstanding such measures; ()

04. Potential Information Loss. Disclosure that information may be lost due to technical failures. ()

015. MEDICAL RECORDS.

As required by Section 54-5711, Idaho Code, any provider providing telehealth services as part of his or her practice shall generate and maintain medical records for each patient. The medical record should include, copies of all patient-related electronic communications, including patient-physician communications, prescriptions, laboratory and test results, evaluations and consultations, relevant information of past care, and instructions obtained or produced in connection with the utilization of telehealth technologies. Informed consents obtained in connection with the provision of telehealth services should also be documented in the medical record. The patient record established

during the provision of telehealth services must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records. ()

016. -- 999. (RESERVED)

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 400 - 404](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, Executive Director, at (208) 334-3110.

DATED this 2nd Day of November 2015.

Sandra Evans, M.A. Ed., R.N., Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Phone: (208) 334-3110 ext. 2476
Fax: (208) 334-3262

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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:

Statute authorizes the Board of Nursing to develop standards and criteria to evaluate the continued competency of licensed nurses. This rulemaking establishes those standards and criteria. For public safety, the rulemaking will require registered and licensed practical nurses seeking to renew their licenses to demonstrate their continued competence to practice nursing in Idaho. The rule establishes several methods for nurses to comply with this obligation.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

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 June 3, 2015 Idaho Administrative Bulletin, [Vol. 15-6, page 52](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, Executive Director, at (208) 334-3110.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 2nd Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1501

061. CONTINUED COMPETENCE REQUIREMENTS FOR RENEWAL OF AN ACTIVE LICENSE.

01. Learning Activities. In order to renew an LPN or RN license, a licensee shall complete or comply with at least two (2) of any of the learning activities listed below in Paragraphs 061.01.a., b., or c. within the two (2)-year renewal period: ()

a. Practice: ()

i. Current nursing specialty certification as defined in Section 402 of these rules; or ()

ii. One hundred (100) hours of practice or simulation practice, paid or unpaid, in which the nurse applies knowledge or clinical judgment in a way that influences patients, families, nurses, or organizations; ()

b. Education, Continuing Education, E-learning, and In-service: ()

i. Fifteen (15) contact hours of continuing education, e-learning, academic courses, nursing-related in-service offered by an accredited educational institution, healthcare institution, or organization (a contact hour equals not less than fifty (50) minutes); or ()

ii. Completion of a minimum of one (1) semester credit hour of post-licensure academic education

relevant to nursing practice, offered by a college or university accredited by an organization recognized by the U.S. Department of Education; or ()

iii. Completion of a Board-recognized refresher course in nursing or nurse residency program; or ()

iv. Participation in or presentation of a workshop, seminar, conference, or course relevant to the practice of nursing and approved by an organization recognized by the Board to include, but not limited to: ()

(1) A nationally recognized nursing organization; ()

(2) An accredited academic institution; ()

(3) A provider of continuing education recognized by another board of nursing; ()

(4) A provider of continuing education recognized by a regulatory board of another discipline; or ()

(5) A program that meets criteria established by the Board; ()

c. Professional Engagement; ()

i. Acknowledged contributor to a published nursing-related article or manuscript; or ()

ii. Teaching or developing a nursing-related course of instruction; or ()

iii. Participation in related professional activities including, but not limited to, research, published professional materials, nursing-related volunteer work, teaching (if not licensee's primary employment), peer reviewing, precepting, professional auditing, and service on nursing or healthcare related boards, organizations, associations or committees. ()

02. APRN Continued Competence Requirements. Registered nurses who also hold an active license as an APRN shall only meet the requirements of Section 300 of these rules. ()

03. First Renewal Exemption. A licensee is exempt from the continued competence requirement for the first renewal following initial licensure by examination. ()

04. Extension. The Board may grant an extension for good cause for up to one (1) year for the completion of continuing competence requirements. Such extension shall not relieve the licensee of the continuing competence requirements. ()

05. Beyond the Control of Licensee Exemption. The Board may, in the exercise of its sound discretion, grant an exemption for all or part of the continuing competence requirements due to circumstances beyond the control of the licensee. ()

06. Disciplinary Proceeding. Continued competence activities or courses required by Board order in a disciplinary proceeding shall not be counted as meeting the requirements for licensure renewal. ()

07. Compliance Effective Dates. Compliance with the continuing competence requirements of Sections 061 and 062 will be necessary to renew an LPN license beginning with 2018 renewals and an RN license beginning with 2019 renewals. ()

062. DOCUMENTING COMPLIANCE WITH CONTINUED COMPETENCE REQUIREMENTS.

01. Retention of Original Documentation. All licensees are required to maintain original documentation of completion for a period of two (2) years following renewal and to provide such documentation within thirty (30) days of a request from the Board for proof of compliance. ()

02. Documentation of Compliance. Documentation of compliance shall be as follows: ()

a. Evidence of national certification shall include a copy of a certificate that includes the name of licensee, name of certifying body, date of certification, and date of certification expiration. Certification shall be initially attained during the licensure period, have been in effect during the entire licensure period, or have been recertified during the licensure period. ()

b. Evidence of post-licensure academic education shall include a copy of the transcript with the name of the licensee, name of educational institution, date(s) of attendance, name of course, and number of credit hours received. ()

c. Evidence of completion of a Board-recognized refresher course shall include certificate or written correspondence from the provider with the name of the licensee, name of provider, and verification of successful completion of the course. ()

d. Evidence of completion of research or a nursing project shall include an abstract or summary, the name of the licensee, role of the licensee as principal or contributing investigator, date of completion, statement of the problem, research or project objectives, methods used, and summary of findings. ()

e. Evidence of contributing to a published nursing-related article, manuscript, paper, book, or book chapter shall include a copy of the publication to include the name of the licensee and publication date. ()

f. Evidence of teaching a course for college credit shall include documentation of the course offering indicating instructor, course title, course syllabus, and the number of credit hours. Teaching a particular course may only be used once to satisfy the continued competence requirement unless the course offering and syllabus has changed in a material or significant fashion. ()

g. Evidence of teaching a course for continuing education credit shall include a written attestation from the director of the program or authorizing entity including the date(s) of the course and the number of hours awarded. ()

h. Evidence of hours of continuing learning activities or courses shall include the name of the licensee, title of activity, name of provider, number of hours, and date of activity. ()

i. Evidence of one hundred (100) hours of practice in nursing shall include the name of the licensee and documentation satisfactory to the Board of the number of hours worked during review period validated by the employer/recipient agency. If self-employed, hours worked may be validated through other methods such as tax records or other business records. If practice is of a volunteer or gratuitous nature, hours worked may be validated by the recipient agency. ()

06~~4~~3. LICENSE REINSTATEMENT (NON-DISCIPLINE).

01. Within One Year. A person whose license has lapsed for failure to pay the renewal fee by the specified date may apply for reinstatement within one (1) year by: (3-30-07)

a. Filing a completed renewal application; and (3-30-01)

b. Payment of the verification of records fee and the renewal fee as prescribed in Subsection 900.05 of these rules. (4-2-03)

02. After One Year. After one (1) year, but less than three (3) years, a person whose license has lapsed for failure to pay the renewal fee by the specified date may apply for reinstatement by: (3-30-07)

a. Filing a completed reinstatement application; and (3-30-01)

b. Payment of the fees prescribed in Subsection 900.05 of these rules; and (3-30-07)

c. Providing evidence satisfactory to the Board of the applicant's ability to practice safely and competently. (3-30-01)

d. Causing the submission of a current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-7-11)

03. After Three Years. After three (3) years, a person whose license has lapsed for failure to timely pay the renewal fee may apply for reinstatement by: (3-30-07)

a. Filing a completed reinstatement application; and (3-30-07)

b. Payment of the fees prescribed in Subsection 900.05 of these rules; and (3-30-07)

c. Payment of the temporary license fee prescribed in Subsection 901.07 of these rules, if required; and (4-2-03)

d. Providing evidence, satisfactory to the Board, of the applicant's ability to practice safely and competently. (3-30-07)

e. Causing the submission of a current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-7-11)

04. Reinstatement of Emeritus License to Current Status. A person who holds a current emeritus license in good standing may apply for reinstatement of the license to active and unrestricted status by: (4-2-03)

a. Submitting a completed application for reinstatement; and (4-2-03)

b. Payment of the fees prescribed in Subsection 900.05 of these rules; and (3-30-07)

c. Providing evidence, satisfactory to the Board, of the applicant's current competency to practice. (3-30-07)

0624. REINSTATEMENT AFTER DISCIPLINE.

01. Submission of Application Materials. A person whose license has been subject to disciplinary action by the Board may apply for reinstatement of the license to active and unrestricted status by: (4-7-11)

a. Submitting a completed application for reinstatement; and (4-7-11)

b. Payment of the fees prescribed in Subsection 900.05 of these rules; and (4-7-11)

c. Documenting compliance with any term and restrictions set forth in any order as a condition of reinstatement; and (4-7-11)

d. Providing evidence, satisfactory to the Board, of the applicant's ability to practice safely and competently. (4-7-11)

e. Causing the submission of a current fingerprint-based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-7-11)

02. Appearance Before Board. Applicants for reinstatement may be required to appear before the Board. (3-15-02)

03. Evaluation of Applications. In considering applications for reinstatement, the Board will evaluate: (3-15-02)

- a. The nature and severity of the act which resulted in discipline; (4-7-11)
 - b. The conduct of the applicant subsequent to the discipline; (4-7-11)
 - c. The lapse of time since discipline; (4-7-11)
 - d. The degree of compliance with all terms and conditions the Board may have set forth as a prerequisite for reinstatement; (3-15-02)
 - e. Any intervening circumstances that may have altered the need for compliance; (3-15-02)
 - f. The degree of rehabilitation attained by the applicant as evidenced by statements sent directly to the Board from qualified people who have professional knowledge of the applicant; (11-28-84)
 - g. The applicant's adherence to or violation of any applicable law or rule regulating the practice of nursing; and (4-6-05)
 - h. The applicant's criminal background information as evidenced by a current fingerprint based criminal history check as set forth in Section 54-1401(3), Idaho Code. (4-6-05)
- 04. Board Action Possible.** After evaluation, the Board may deny a reinstatement, grant a reinstatement, or issue a license permitting the applicant to practice nursing under specified terms and conditions. (3-15-02)
- 05. Assessment of Costs.** As a condition of withdrawing, reversing, modifying, or amending a prior disciplinary order, the applicant may be required to pay all or any part of the costs incurred by the Board in the proceedings in which the order was entered. (4-7-11)
- 06. Application for Reinstatement After Revocation.** Unless otherwise provided in the order of revocation, applicants for reinstatement of revoked licenses may not apply for reinstatement for a period of two (2) years after entry of the order. (3-15-02)
- 0635. -- 075. (RESERVED)**

IDAPA 23 - BOARD OF NURSING

23.01.01 - RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1503

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1404, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 405 - 407](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, Executive Director, at (208) 334-3110.

DATED this 2nd Day of November 2015.

Sandra Evans, M.A. Ed., R.N., Executive Director
Board of Nursing
280 N. 8th St. (8th & Bannock), Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Phone: (208) 334-3110 ext. 2476
Fax: (208) 334-3262

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

The existing Board of Nursing rule on specialized practice is inadequate and the Board has received requests to update the rule. This rulemaking amends Board of Nursing Rule 402 (IDAPA 23.01.01.402) to update and clarify provisions regarding registered nurses functioning in a specialty area of nursing.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

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 June 3, 2015 Idaho Administrative Bulletin, **Vol. 15-6, page 54**.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, Executive Director, at (208) 334-3110.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 2nd Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1503

402. LICENSED REGISTERED NURSE FUNCTIONING IN SPECIALITY AREAS.

01. Extended Functions. A licensed registered nurse may carry out functions beyond the basic educational preparation described in Sections 600 through 681 of these rules under certain conditions. ~~(7-1-96)~~(____)

042. Conditions for Licensed Registered Nurses Functioning in Specialty Practice Areas. A licensed registered nurse may carry out functions ~~beyond the educational preparation described in Sections 600 through 681 of these rules~~ defined within parameters of a nursing specialty that meets criteria approved by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA) of the National Organization for Competency Assurance (NOCA) when the nurse: ~~(3-30-07)~~(____)

a. ~~In addition to~~ Can document successful completion of ~~the curriculum requirements~~ additional education through an organized program of study including supervised clinical experience or equivalent demonstrated competence consistent with provisions of Sections ~~600 through 681~~ 400 of these rules, ~~has completed any specific education, training, and supervised practice as may be required in the Nursing Practice Act or rules; and~~ ~~(3-30-07)~~(____)

b. Conforms to recognized nursing specialty practice parameters, characters, and standards for practice of the specialty. ~~and~~ ~~(5-3-03)~~(____)

c. ~~Follows written protocols approved by medical staff, nursing administration, and the employing~~

~~agency administration. (5-3-03)~~

~~**02. Recognized Specialty Practice Areas.** Additional education, training, and practice: (5-3-03)~~

~~**a.** Flight/Transport Nurse. A flight/transport nurse is a licensed registered nurse who provides critical care services with a duly licensed transporting agency. (5-3-03)~~

~~i. Basic qualifications include at least two (2) years (four thousand (4,000) hours) of critical care nursing experience in the specialty area pertinent to the type of service being provided. (5-3-03)~~

~~ii. Licensed registered nurses who regularly provide care in the pre-hospital setting must maintain emergency medical technician credentialing. (5-3-03)~~

~~iii. Individual educational requirements commensurate with the specialty care being provided may include, but are not limited to: Neonatal Resuscitation Program ("NRP"), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Trauma Nurse Core Curriculum (TNCC) or Flight Nurse Advanced Trauma Course (FNATC) and radio communications. (5-3-03)~~

~~iv. Flight nurses must also have course work in flight physiology, aircraft safety and survival. (5-3-03)~~

~~v. A flight/transport nurse must have received a minimum of forty (40) hours of supervised clinical experience before functioning independently. (5-3-03)~~

~~**b.** Surgical First Assistants. A surgical first assistant is a licensed registered nurse who, under direct supervision, assists the operating surgeon. (5-3-03)~~

~~i. Nurses acting as surgical first assistants may not concurrently serve as scrub or instrument nurses. (5-3-03)~~

~~ii. A licensed registered nurse surgical first assistant in cardiovascular surgery may harvest saphenous veins after completing additional educational instruction acceptable to the Board and supervised practice under direct supervision of the operating physician. (5-3-03)~~

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.03.01 - RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

DOCKET NO. 24-0301-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date as specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-707, Idaho Code.

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

This pending rule adopts the amendments made in the proposed rule to Rule 20. This rule is being amended to remove the words “in all their forms” and to make sure everyone understands that clinical nutritional methods cannot exceed the scope of practice set forth in 54-704(2), Idaho Code.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 416 and 417](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 23rd day of November, 2015.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
P.O. Box 83720
Boise, ID 83702
Ph. (208) 334-3233
Fax (208) 334-3945

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-707, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not

later than five (5) days prior to the hearing, to the agency address below.

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

Rule 20 is being amended to remove the words “in all their forms” and to make sure everyone understands that clinical nutritional methods cannot exceed the scope of practice set forth in 54-704(2), Idaho Code.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the revisions to this rule are simple in nature. This proposal was discussed during noticed, open meetings of the Board with interested parties in attendance.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 577-2584.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0301-1501

020. SCOPE OF PRACTICE (RULE 20).

Clinical nutritional methods as referenced in Section 54-704, Idaho Code, include, but are not limited to, the clinical use, administration, recommendation, compounding, prescribing, selling, and distributing vitamins, minerals, botanical medicine, herbals, homeopathic, phytonutrients, antioxidants, enzymes and glandular extracts, and durable and non-durable medical goods and devices ~~in all their forms~~. Nothing herein shall allow any deviation from Section 54-704(2), Idaho Code. ~~(4-2-08)~~()

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.06.01 - RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

DOCKET NO. 24-0601-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3717, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 422 - 427](#).

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than \$10,000 during the fiscal year: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 3rd Day of November, 2015.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
P.O. Box 83720
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-3717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

Due to the passage of House Bill 24 in the 2015 session, which deleted Professional Development Units (PDU's), the rules need to be amended to delete references to PDU's. The rule changes clarify the time when continuing education is required for renewal of licenses. The rule changes also decrease the number of supervised clinical hours required for deep thermal and electrotherapeutic modalities and wound care from 160 to 40 hours.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because of the passage of House Bill 24. Revisions to this rule bring the rule into compliance with the statute regarding continuing education. There is also a reduction in the required number of supervised clinical training hours for deep thermal and electrotherapeutic modalities and wound care. These rules were discussed in a noticed, open meeting of the Board.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 577-2584.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0601-1501

004. INCORPORATION BY REFERENCE.

The "PDU Activities Chart" on pages 14-17 of the document titled National Board for Certification in Occupational Therapy (NBCOT), Inc. Certification Renewal Handbook, 2012, as published by the NBCOT, Inc. and copyrighted to NBCOT, Inc. in 2012, which is referenced in Subsection 025.01.b. of these rules. All documents incorporated by reference are available at the Board's office and through the Board's website There are no documents incorporated by reference into this rule. *(4-4-13)()*

(BREAK IN CONTINUITY OF SECTIONS)

012. DEEP THERMAL AND ELECTROTHERAPEUTIC MODALITIES, AND WOUND CARE.

01. Qualifications. Except as provided in Subsection 012.02 of these rules, a person may not utilize occupational therapy techniques involving deep thermal, electrotherapeutic modalities or perform wound care management unless the person is licensed by the Board as an occupational therapist and certified by the Hand Therapy Commission. In lieu of being certified by the Hand Therapy Commission, the person must have obtained education and training as described in Paragraphs 012.01.a. through 012.01.c. of this rule. (4-7-11)

a. If the person utilizes techniques involving deep thermal, electrotherapeutic modalities, the person must have successfully completed three (3) continuing education units in the application of deep thermal and electrotherapeutic modalities, along with ~~one hundred sixty (160)~~ forty (40) hours of supervised, on-the-job or clinical internship or affiliation training pertaining to such modalities. (4-7-11)()

b. If the person manages wound care, the person must have successfully completed one and one-half (1.5) continuing education units in wound care management, along with ~~one hundred sixty (160)~~ forty (40) hours of supervised, on-the-job or clinical internship or affiliation training pertaining to wound care management. (4-7-11)()

c. If the person utilizes both deep thermal, electrotherapeutic modalities and manages wound care, the person's forty (40) hours of supervised, on-the-job or clinical internship or affiliation training ~~for each~~ may ~~have overlapped, so that the one hundred sixty (160) hours for each were~~ be obtained concurrently through the same forty (40) hours of supervised, on-the-job or clinical internship or affiliation, provided that such internship or training includes both the use of deep thermal, electrotherapeutic modalities and the management of wound care. (4-7-11)()

02. Obtaining Education and Supervised Training. A student occupational therapist, graduate occupational therapist, and an occupational therapist may utilize deep thermal, electrotherapeutic modalities or manage wound care while working towards obtaining the education and supervised training described in Section 012 of these rules. The supervisor must provide at least direct supervision to the student occupational therapist, and at least routine supervision to the graduate occupational therapist or occupational therapist. An occupational therapy assistant may apply deep thermal and electrotherapeutic modalities under routine supervision if the occupational therapy assistant has obtained an advanced level of skill as described in Subsection 011.01 of these rules and the education and training described in Subsection 012.01 of these rules. Otherwise, the occupational therapy assistant must work under direct supervision while applying such modalities. (4-7-11)

03. Supervised Training by Qualified Individual. The supervised training described in Section 012 of these rules must be provided by an occupational therapist who is qualified as specified in this Subsection 012.01, or by another type of licensed health care practitioner whose education, training, and scope of practice enable the practitioner to competently supervise the person as to the modalities utilized and wound care management provided. (4-7-11)

(BREAK IN CONTINUITY OF SECTIONS)

022. LICENSE EXPIRATION AND RENEWAL.

01. Expiration Date. An individual's license expires on the individual's birth ~~day~~ date. The individual must annually renew the license before the individual's birth ~~day~~ date in accordance with Section 67-2614, Idaho Code. Licenses not so renewed will be cancelled in accordance with Section 67-2614, Idaho Code. (3-29-10)()

02. Reinstatement. A license cancelled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code. Reinstatement of a license from inactive to active status is governed by Section 030. (4-7-11)

03. Application for Renewal. In order to renew a license, a licensee must submit a timely, completed, Board-approved renewal application form and pay the required renewal fees. (3-29-10)

(BREAK IN CONTINUITY OF SECTIONS)

025. CONTINUING EDUCATION.

In order to protect public health and safety and promote the public welfare, the Board has adopted the following continuing education requirement ~~consisting of both continuing education units (CEUs) and professional development units (PDUs)~~ of all licensees: (3-29-10)()

01. Requirement. ~~Every two (2) years, a licensee must complete at least two (2) CEUs approved by the Board, along with at least ten (10) Board-approved professional development units (PDUs). The licensee's initial two (2) year period shall begin on the date on which this Board issues the licensee a license and end on the date on which the licensee submits the licensee's second renewal application. Thereafter, the two (2) year period shall begin to run from the date of each renewal application in which the licensee was required to verify the completion of continuing education. Until January 1, 2018, each licensee shall successfully complete, in the two (2) years preceding renewal of the license, a minimum of two (2) Board-approved continuing education units (CEUs).~~ (4-4-13)()

a. Effective January 1, 2018 each licensee shall successfully complete, in the two (2) years prior to the license expiration date, a minimum of two (2) Board-approved CEUs. ()

#b. A CEU is a measurement of the licensee's participation in a Board-approved continuing education activity. One (1) CEU requires ten (10) contact hours of participation in a Board-approved continuing education program, excluding meals and breaks. One (1) contact hour equals one (1) clock hour for purpose of obtaining CEUs. (3-29-10)

~~**b.** A PDU is a measurement of the licensee's participation in a professional development activity. One (1) contact hour of participation in Board approved professional development activity equals one (1) PDU; one (1) academic credit equals ten (10) PDUs, and one (1) CEU equals ten (10) PDUs. If a licensee counts a CEU towards fulfilling the PDU requirement in a given two-year period, the CEU unit will not count towards fulfilling the CEU requirement. Accepted PDU activities and their associated PDU values are set forth in the PDU Activities Chart at pages 14-17 of the NBCOT Certification Renewal Handbook, as incorporated by reference in Section 004 of these rules.~~ (3-29-10)

c. The Board shall waive the continuing education requirement for the first two (2) license renewals after initial licensure. ()

02. Verification. The licensee must verify to the Board, as part of the annual license renewal process, that the licensee is in compliance with the continuing education requirement. (3-29-10)

03. Courses and Activities. At least one (1) CEU ~~and five (5) PDUs~~ must directly relate to the delivery of occupational therapy services. The remaining ~~PDUs and~~ CEUs must be germane to the practice of occupational therapy and relate to other areas of a licensee's practice. A licensee may take online or home study courses, as long as a course completion certificate is provided. (3-29-10)()

a. CEUs ~~and PDUs~~ acceptable to the Board include, but are not limited to, programs or activities sponsored by the American Occupational Therapy Association (AOTA) or the Idaho Occupational Therapy Association (IOTA); post-professional coursework completed through any approved or accredited educational institution that is not part of a course of study leading to an academic degree; or otherwise meet all of the following criteria: (3-29-10)()

- i. The program or activity contributes directly to professional knowledge, skill, and ability; (3-29-10)
- ii. The program or activity relates directly to the practice of occupational therapy; and (3-29-10)
- iii. The program or activity must be objectively measurable in terms of the hours involved. (3-29-10)

- b. Partial credit will not be given for CEUs ~~and PDUs~~. (3-29-10)()
- c. The delivery of occupational therapy services may include: models, theories or frameworks that relate to client/patient care in preventing or minimizing impairment, enabling function within the person/environment or community context. (3-29-10)
- d. Other activities may include, but are not limited to, occupation based theory assessment/interview techniques, intervention strategies, and community/environment as related to one's practice (3-29-10)
- 04. Carry Over and Duplication.** CEUs ~~and PDUs~~ cannot be carried over to the next reporting period. The same course taken more than once during a reporting cycle will only be counted once. (3-29-10)()
- 05. Documentation.** A licensee need not submit documentation of CEUs ~~and PDUs~~ when the licensee renews a license. However, a licensee must maintain documentation verifying that the licensee has completed the continuing education requirement for a period of four (4) years. A licensee must submit the verification documentation to the Board if the licensee is audited by the Board. A percentage of occupational therapists and certified occupational therapy assistants will be audited every year. Documentation for all activities must include licensee's name, date of activity or when course was completed, provider name, course title, description of course/activity, and number of CEUs. (3-29-10)()
- ~~a. Documentation for all activities must include licensee's name, date of activity or when course was completed, provider name, course title, description of course/activity, and number of PDUs and CEUs. (3-29-10)~~
- ~~b. Records showing participation in each professional development activity must be maintained by the licensee. Acceptable documentation for specific activities includes: (3-29-10)~~
- ~~a.~~ Continuing education course work. The required documentation for this activity is a certificate or documentation of attendance. (3-29-10)
- ~~b.~~ In-service training. The required documentation for this activity is a certificate or documentation of attendance. (3-29-10)
- ~~c.~~ Professional conference or workshop. The required documentation for this activity is a certificate or documentation of attendance. (3-29-10)
- ~~d.~~ Course work offered by an accredited college or university, provided that the course work is taken after the licensee has obtained a degree in occupational therapy, and the course work provides skills and knowledge beyond entry-level skills or knowledge. The required documentation for this activity is a transcript. (3-29-10)
- ~~e.~~ Publications. The required documentation for this activity is a copy of the publication. (3-29-10)
- ~~f.~~ Presentations. The required documentation for this activity is a copy of the presentation or program listing. Any particular presentation may be reported only once per reporting period. (3-29-10)
- ~~g.~~ Interactive online courses. The required documentation for this activity is a certificate or documentation of completion. (3-29-10)
- ~~h.~~ Development of instructional materials incorporating alternative media such as video, audio and/or software programs to advance professional skills of others. The required documentation for this activity is a program description. The media/software materials must be available if requested during audit process. (3-29-10)
- ~~i.~~ Professional manuscript review. The required documentation for this activity is a letter from publishing organization verifying review of manuscript. A maximum of ten (10) hours is allowed per reporting period for this category. (3-29-10)
- ~~j.~~ Guest lecturer for occupational therapy related academic course work (academia not primary role).

The required documentation for this activity is a letter or other documentation from instructor. (3-29-10)

~~iii~~**k.** Serving on a professional board, committee, disciplinary panel, or association. The required documentation for this activity is a letter or other documentation from the organization. A maximum of ten (10) hours is allowed per reporting period for this category. (3-29-10)

~~iii~~**l.** Self study of cassette, tape, video tape, or other multimedia device, or book. The required documentation for this activity is a two (2) page synopsis of each item written by the licensee. A maximum of ten (10) hours is allowed per reporting period for this category. (3-29-10)

~~iii~~**m.** Level II fieldwork direct supervision of an occupational therapy student or occupational therapy assistant student by site designated supervisor(s). The required documentation for this activity is a name of student(s), letter of verification from school, and dates of fieldwork. A maximum of ten (10) hours per supervisor is allowed per reporting period for this category. (3-29-10)

06. Exemptions. A licensee may request an exemption from the continuing education requirement for a particular two-year (2) period under the following circumstances. The licensee must provide any information requested by the Board to assist in substantiating the licensee's need for a claimed exemption: (3-29-10)

a. During the continuing education period the licensee was residing in another country for one (1) year or longer, reasonably preventing completion of the continuing competency requirements; (3-29-10)

b. The licensee was absent from Idaho because of military service for a period of one (1) year or longer during the continuing education period, preventing completion of the continuing competency requirements; or (3-29-10)

c. The licensee should be exempt from the continuing ~~competency~~ **education** requirements for reasons of health or other good cause. ~~(3-29-10)~~ **()**

(BREAK IN CONTINUITY OF SECTIONS)

030. INACTIVE STATUS.

01. Request for Inactive Status. Occupational Therapists and Occupational Therapy Assistants requesting an inactive status during the renewal of their active license must submit a written request and pay the established fee. (4-7-11)

02. Inactive License Status. (4-7-11)

a. Licensees may not practice in Idaho while on inactive status. (4-7-11)

b. All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing or supervising in Idaho, subject to Subsection 030.03 of these rules. (4-7-11)

c. Inactive license renewal notices and licenses will be marked "Inactive." (4-7-11)

03. Reinstatement to Full Licensure from Inactive Status. An inactive licensee may reinstate to active status by submitting a completed, Board-approved application and paying the appropriate fee. The licensee's application must demonstrate, to the Board's satisfaction, that during the two (2) years immediately preceding the application, the licensee completed at least two (2) CEUs ~~recommended by the Idaho Occupational Therapy Association and approved by~~ **acceptable to** the Board, ~~along with at least ten (10) Board-approved professional development units (PDUs), as specified in Section 025 of these rules.~~ **(4-7-11)** **()**

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.15.01 - RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

DOCKET NO. 24-1501-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3404, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 435 - 439](#).

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than \$10,000 during the fiscal year: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 3rd Day of November, 2015.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
P.O. Box 83720
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE
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AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-3404, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not

later than five (5) days prior to the hearing, to the agency address below.

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

The American Association for Marriage and Family Therapy (AAMFT) Code of Ethics was updated January 1, 2015 and the Board has adopted the updated code. The counselor supervisor registration requirements are being amended to limit approvals to five years and to create a renewal process. The clinical professional counselor requirements are being clarified, the marriage and family therapists supervisor requirements are being amended to align with the requirements for a counselor supervisor and to create a renewal process.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the proposed changes to these rules were discussed during noticed, open meetings of the Board.

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

The AAMFT Code of Ethics was updated January 1, 2015 and the Board has adopted the updated code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 577-2584.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1501-1501

004. INCORPORATION BY REFERENCE (RULE 4).

01. ACA Code of Ethics. "ACA Code of Ethics," as published by the American Counseling Association (ACA), effective 2014, is herein incorporated by reference and is available from the Board's office and on the Board web site. (4-11-15)

02. AAMFT Code of Ethics. The document titled "AAMFT Code of Ethics," as published by the American Association for Marriage and Family Therapy (AAMFT), effective ~~July~~ January 1, 201~~2~~5 and referenced in Subsections 239, 350, ~~and 450-01~~, and 525 is herein incorporated by reference and is available from the Board's office and on the Board web site. (~~4-4-13~~)()

03. Guidelines. The document titled "Approved Supervision Designation Handbook" that provides supervision guidelines for supervisors, as published by the American Association for Marriage and Family Therapy (AAMFT), dated October 2007 referenced in Subsection 239.03.a. of these rules, is herein incorporated by reference

and is available from the Board's office and on the Board web site at <http://www.ibol.idaho.gov>. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

200. COUNSELOR SUPERVISOR REQUIREMENTS (RULE 200).

Effective July 1, 2004, Idaho licensed counselors shall be registered with the Board in order to provide supervision for those individuals pursuing licensure in Idaho as a counselor. (3-29-12)

01. Requirements for Registration. (4-2-03)

- a.** Document at least two (2) years experience as a licensed counselor. (3-30-07)
- b.** Document at least one thousand five hundred (1,500) hours of direct client contact as a counselor. (4-2-03)
- c.** Document fifteen (15) contact hours of education in supervisor training as approved by the Board. (4-2-03)
- d.** Have not been the subject of any disciplinary action for five (5) years prior to application for registration. (4-2-03)

02. Registration. A supervisor applicant shall submit to the Bureau a completed application form as approved by the Board. (4-2-03)

a. Upon receipt of a completed application verifying compliance with the requirements for registration as a supervisor, the applicant shall be registered as a supervisor. The applicant shall include a copy of the informed consent form used to ensure clients are aware of the roles of the supervisor and supervisee, (3-29-12)

b. A supervisor's registration shall be valid only so long as the ~~individual supervisor's~~ counselor license remains current and in good standing. is not disciplined, and is renewed as provided in these rules. (4-2-03)()

03. Supervision. (4-2-03)

a. A Registered Counselor Supervisor shall provide supervision in conformance with the guidelines for supervisors set forth in the ACA Code of Ethics. (3-29-12)

b. Unless the primary work role of an individual is as a clinical supervisor a Registered Counselor Supervisor shall not provide supervision to more than six (6) supervisees concurrently. (3-29-12)

c. Supervision shall be provided in a face-to-face setting. Face-to-face setting may include a secure live electronic face-to-face connection between the supervisor and supervisee. ()

04. Renewal. Subject to the conditions in Paragraph 200.04.c. of this rule, a supervisor's registration is valid for a term of five (5) years. To renew a supervisor registration, the registered supervisor must submit to the Board a complete application for registration renewal prior to the expiration of the current registration on forms approved by the Board and meet the following requirements: ()

a. Hold an active Idaho counselor license which has not been subject to discipline and is current and in good standing; and ()

b. Document six (6) hours of continuing education in advanced supervisor training as approved by the Board and completed within the previous five (5) years. ()

c. For supervisors registered prior to the effective date of Subsection 200.04 of this rule, the following

renewal requirements and conditions apply: ()

i. A registered supervisor who has been registered for at least five (5) years prior to July 1, 2016 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2018. ()

ii. A registered supervisor who has been registered for less than five (5) years prior to July 1, 2016 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2020. ()

201. -- 224. (RESERVED)

225. CLINICAL PROFESSIONAL COUNSELOR LICENSURE (RULE 225).

Licensure as a "clinical professional counselor" shall be restricted to persons who have successfully passed the required examination and have met the following requirements: (3-29-12)

01. License. Hold a valid licensed professional counselor license that is current and in good standing; and (3-29-12)()

02. Experience. Document two thousand (2,000) hours of direct client contact experience under supervision accumulated in no less than a two (2) year period after licensure in any state. (3-29-12)

a. All applicants for Clinical Professional Counselor license must provide verification of meeting at least one thousand (1,000) hours of supervised experience under the supervision of a licensed Clinical Professional Counselor registered as a supervisor with the Board. The remainder of the supervision may be provided by licensed Psychiatrists, Licensed Psychologists, Licensed Clinical Social Workers registered as supervisors with the Board of Social Work Examiners, or Marriage and Family Therapists registered as supervisors with the Board. If the applicant's supervision was provided in another state, it must have been provided by a counseling professional licensed by that state, provided the requirements for license and supervision are substantially equivalent to the requirements of Title 54, Chapter 34, Idaho Code. (3-29-12)()

b. One (1) hour of clinical supervision for every thirty (30) hours of direct client contact is required. Individual supervision is defined as one (1) hour of face-to-face, one-on-one (1:1) or one-to-two (1:2) supervision to every thirty (30) hours of direct client contact. Supervision shall be provided in a face-to-face setting. Face-to-face setting may include a secure live electronic face-to-face connection between the supervisor and supervisee. (3-29-12)()

c. No more than one-half (1/2) of group supervision shall be allowed. (3-30-07)

03. Examination. Successful passage of the required written examination. (3-29-12)

04. Recommendation of the Supervisor(s). The Board shall consider the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

239. MARRIAGE AND FAMILY THERAPIST SUPERVISOR REQUIREMENTS (RULE 239).

Effective July 1, 2004, licensed marriage and family therapists in Idaho shall be registered with the board to provide supervision for those individuals pursuing licensure in the state of Idaho as a marriage and family therapist.(3-20-04)

01. Requirements for Registration. (3-20-04)

a. Possess two (2) years experience as a licensed marriage and family therapist and document at least two thousand (2,000) hours of direct client contact with couples and families. (3-20-04)

b. Document fifteen (15) contact hours of education in supervisor training as approved by the Board.

(3-20-04)

- c. Have not been subject to discipline for five (5) years prior to registration. (3-20-04)

02. Registration. A marriage and family therapist shall fully complete the application form as established by the board and submit the designated fee as adopted by board rule. (3-20-04)

a. Upon receipt of a completed application verifying compliance with the requirements for registration as a supervisor, the applicant shall be registered as a supervisor. The applicant shall include a copy of the informed consent form used to ensure clients are aware of the roles of the supervisor and supervisee. ()

b. A supervisor's registration shall be valid only so long as the supervisor's marriage and family therapist license remains current and in good standing, is not disciplined, and is renewed as provided in these rules. ()

03. Supervision. (3-20-04)

a. A registered marriage and family therapist supervisor shall provide supervision in conformance with the guidelines for supervisors adopted by the American Association for Marriage and Family Therapists and the guidelines set forth in the AAMFT Code of Ethics. (3-20-04)()

b. Unless the primary work role of an individual is as a clinical supervisor a registered marriage and family therapist shall not supervise more than six (6) supervisees, either in one-to-one or group supervision, at any time regardless of the modality (individual, dyad, or group) of supervision. (3-29-12)

c. Supervision shall be provided in a face-to-face setting. Face-to-face setting may include a face-to-face setting provided by a secure live electronic connection between the supervisor and supervisee. (3-29-12)()

04. Renewal. Subject to the conditions in Paragraph 239.04.c. of this rule, a supervisor's registration is valid for a term of five (5) years. To renew a supervisor registration, the registered supervisor must submit to the Board a complete application for registration renewal prior to the expiration of the current registration on forms approved by the Board and meet the following requirements: ()

a. Hold an active Idaho marriage and family therapist license which has not been subject to discipline and is current and in good standing; and ()

b. Document six (6) hours of continuing education in advanced supervisor training as approved by the Board and completed within the previous five (5) years. ()

c. For supervisors registered prior to the effective date of Subsection 239.04 of this rule, the following renewal requirements and conditions apply: ()

i. A registered supervisor who has been registered for at least five (5) years prior to July 1, 2016 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2018. ()

ii. A registered supervisor who has been registered for less than five (5) years prior to July 1, 2016 must submit a complete application for registration renewal and meet the renewal requirements by July 1, 2020. ()

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES

24.17.01 - RULES OF THE STATE BOARD OF ACUPUNCTURE

DOCKET NO. 24-1701-1501

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-4705, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 440 - 442](#).

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than \$10,000 during the fiscal year: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cherie Simpson at (208) 334-3233.

DATED this 3rd Day of November, 2015.

Tana Cory
Bureau Chief
Bureau of Occupational Licenses
700 W. State Street
P.O. Box 83720
Boise, ID 83702
(208) 334-3233 Ph.
(208) 334-3945 fax

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-4705, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

The rule is being amended to clarify the continuing education needed to reinstate an expired license and the Board is adding continuing education credit, with limitations, for licensees who teach Board-approved courses.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule is being amended to clarify the continuing education needed to reinstate an expired license and the Board is adding continuing education credit for teaching. The proposed changes to these rules were discussed during, noticed, open meetings of the Board.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cherie Simpson at (208) 577-2584.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September, 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1701-1501

301. RENEWAL OR REINSTATEMENT OF LICENSE (RULE 301).

01. Expiration Date. All Acupuncture licenses and certificates expire and must be renewed annually on forms approved by the Board together with the required fee in accordance with Section 67-2614, Idaho Code. As part of a complete renewal application, the licensee will certify by signed affidavit completion of the required continuing education pursuant to Sections 305 through 307 of these rules. Licenses and certificates not so renewed will be cancelled in accordance with Section 67-2614, Idaho Code. (4-4-13)

02. Reinstatement. Any license or certificate cancelled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code, with the exception that the reinstatement fee shall be two hundred fifty dollars (\$250) and the applicant shall submit proof of having met the required continuing education for each year the license or certificate was cancelled. required of licensees by Section 305 through 307 of these rules as follows: (5-3-03)()

- a. For licenses or certificates expired for one (1) year or less, one (1) year of continuing education: ()
- b. For licenses or certificates expired for more than one (1) year, two (2) years of continuing

education.

()

(BREAK IN CONTINUITY OF SECTIONS)

305. CONTINUING EDUCATION REQUIREMENTS (RULE 305).

In order to further protect the public health and to facilitate the administration of the Acupuncture Act, the Board has adopted the following requirements: (4-4-13)

01. Requirement. All practitioners, for renewal of their license or certificate, shall be required to complete a minimum of fifteen (15) hours of continuing education within the preceding twelve (12) months. Beginning July 1, 2014, a minimum of ten (10) hours of continuing education must be from Category I topics, and a maximum of five (5) hours of continuing education may be from Category II topics, as set forth in Sections 306 and 307 of these rules. (4-4-13)

02. Verification of Attendance. It shall be necessary for each licensee to maintain verification of attendance by securing authorized signatures or other documentation from the course instructors or sponsoring institution substantiating any hours attended by the applicant. This verification shall be maintained by the licensee for no less than seven (7) years and provided to the Board upon the request of the Board or its agent. (5-3-03)

03. Distance Learning and Independent Study. The Board may approve a course of study for continuing education credit that does not include the actual physical attendance of the applicant in a face-to-face setting with the course instructor. Distance Learning or Independent Study courses shall be eligible for continuing education credits if approved by NCCAOM or upon approval of the Board. (4-6-05)

04. Special Exemption. The Board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board. (4-6-05)

05. Carryover. A continuing education course taken in a renewal year, but not claimed for continuing education credit in that year, may only be claimed for credit in the following renewal year. (4-4-13)

06. Credit for Teaching. Licensees may earn continuing education credit by teaching Board-approved courses. A licensee will earn one (1) credit hour for every two (2) hours of teaching. Credit for teaching will not exceed five (5) hours of the total continuing education hours required for a renewal period and will be credited to the category of the topic taught. ()

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1502

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

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

The changes clarify the permissible and impermissible dispensing scenarios for institutional pharmacies. In particular, the changes clarify that the limitations on quantity and duration do not apply to current hospital employees, medical staff, and students at the hospital, or their dependents.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 486 through 488](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Alex Adams, Executive Director, at (208) 334-2356.

DATED this 3rd Day of November 2015.

Alex Adams
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Phone: 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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

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

This rulemaking is necessary to clarify the dispensing of drugs and devices within an institutional facility. This rulemaking provides new language to clarify and list to whom an institutional facility may dispense drugs and devices.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

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 under Docket No. 27-0101-1501 in the July 1, 2015 Idaho Administrative Bulletin, **Vol. 15-7, page 71** and in the August 5, 2015 Idaho Administrative Bulletin, **Vol. 15-8, page 106**.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams, Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September 2015.

LSO Rules Analysis Memo

Italicized red text that is **double underscored** is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1502

620. INSTITUTIONAL FACILITY: PRACTICE OF PHARMACY AND ADMINISTRATION AND CONTROL OF DRUGS AND DEVICES.

These institutional facility rules are applicable to the practice of pharmacy and the administration and control of drugs and devices ~~within~~ by institutional facilities or by persons employed by them. ~~(3-21-12)~~ ()

(BREAK IN CONTINUITY OF SECTIONS)

630. INSTITUTIONAL FACILITY: GENERAL STANDARDS FOR ADMINISTRATION AND CONTROL OF DRUGS AND DEVICES.

~~01. Drugs and Devices Dispensed for Administration or Use Within an Institutional Facility.~~ Within an institutional facility, drugs and devices may be dispensed for administration to, or for self-administration or use by, a patient ~~while in the institutional facility~~ only as permitted by applicable law and these rules consistent with usual and customary standards of good medical practice, ~~as follows:~~ (3-21-12)()

01. Drugs and Devices Dispensed for Administration Within an Institutional Facility. Drugs and devices must only be dispensed to inpatients of an institutional facility: ()

- a. Upon the drug orders of licensed facility prescribers; (3-21-12)
- b. Pursuant to an emergency protocol for the administration of drugs without an order in life or death situations; ~~and~~ or (3-21-12)()
- c. ~~By~~ For self-administration or use if specifically authorized by the treating or ordering prescriber, the patient has been appropriately educated and trained to perform self-administration, and there is no risk of harm. (3-21-12)()

02. Drugs and Devices Dispensed for Administration or Use Outside an Institutional Facility. A drug or device prepared for self-administration or use by a patient while outside the confines of the institutional facility must comply with the standard prescription drug labeling requirements, subject to the following: (3-21-12)()

- a. Permissible dispensing: ()
 - i. In limited quantities and reasonable time duration as a continuation of or supplemental to treatment that was administered at the hospital to the following: ()
 - (1) To emergency room patients pursuant to these rules; and ()
 - (2) To other outpatients who receive treatment or consultation on the premises; ()
 - ii. To hospital employees, medical staff, and students at the hospital and their dependents, for their own personal use only and not for resale. ()
- b. Impermissible dispensing: ()
 - i. To former patients, employees, medical staff, students, and their dependents; and ()
 - ii. To walk up customers who have no connection to the hospital. ()

03. Controlled Substances Reporting and Documentation. Distribution, dispensing, delivery, or administration of controlled substances within an institutional facility or by facility personnel must be properly and adequately documented and reported in the time and manner required by the appropriate committee of the institutional facility and the director. (3-21-12)

04. Patient's Personal Drug Supplies. If an admitted patient brings a drug into the institutional facility, the drug must not be administered or used except pursuant to a drug order and only if it can be precisely identified and the quantity and quality of the drug visually evaluated by a pharmacist. (3-21-12)

- a. If a patient's drug will not be administered or used, the pharmacy must package, seal, and return the drug to an adult member of the patient's immediate family or store and return it to the patient upon discharge. (3-21-12)
- b. Drugs not returned to the patient or the patient's family may be disposed of after a reasonable

number of days following discharge or death. (3-21-12)

05. Suspected Adverse Drug Reaction Reporting. Suspected adverse drug reactions must be communicated in a timely manner to the pharmacy. (3-21-12)

06. Required Pharmacy Returns. Discontinued, expired, and damaged drugs and containers with worn, illegible, or missing labels must be returned to the pharmacy for proper handling. (3-21-12)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1503

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

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

The changes remove the proposed addition of the prescriber's phone number to the prescription blank, and restore the current requirement that the prescriber's address is on a controlled substance prescription.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 489 through 496](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Alex Adams, Executive Director, at (208) 334-2356.

DATED this 3rd day of November 2015.

Alex Adams
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Phone: 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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 docket streamlines, clarifies and adds missing or incomplete language. Current language is missing in the definitions associated with compounding of drugs. These changes clarify the language to add a hazardous drug definition, and definitions of USP 795 and USP 797. The changes clarify the components of a prescription drug order to include the prescriber phone number. These changes add language to allow certain product preparations to not be considered compounded if combined according to the manufacturer's labeling.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

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 under Docket No. 27-0101-1501 in the July 1, 2015 Idaho Administrative Bulletin, [Vol. 15-7, page 71](#) and in the August 5, 2015 Idaho Administrative Bulletin, [Vol. 15-8, page 106](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams, Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1503

010. DEFINITIONS AND ABBREVIATIONS (A -- I).

01. Accredited School or College of Pharmacy. A school or college that meets the minimum standards of the ACPE and appears on its list of accredited schools or colleges of pharmacy. (3-21-12)

02. ACPE. Accreditation Council for Pharmacy Education. (3-21-12)

03. Acute Care Hospital. A facility in which concentrated medical and nursing care is provided by, or under the supervision of, physicians on a twenty-four (24) hour basis to inpatients experiencing acute illnesses. (3-21-12)

- 04. ADS -- Automated Dispensing and Storage.** A mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, dispensing, or distribution of drugs and that collects, controls, and maintains transaction information. (3-21-12)
- 05. Biological Product.** A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), that is applicable to the prevention, treatment, or cure of a disease or condition of human beings and licensed under Section 351(k) of the Public Health Service Act, 42 U.S.C. Section 262(i). (4-11-15)
- 06. Biosimilar.** A biological product highly similar to a specific reference biological product that is licensed by the FDA pursuant to 42 U.S.C. Section 262(k) and published in the Purple Book. (4-11-15)
- 07. CDC.** United States Department of Health and Human Services, Centers for Disease Control and Prevention. (3-21-12)
- 08. Central Drug Outlet.** A resident or nonresident pharmacy, drug outlet or business entity employing or contracting pharmacists to perform centralized pharmacy services. (7-1-13)
- 09. Central Pharmacist.** A pharmacist performing centralized pharmacy services. (7-1-13)
- 10. Central Pharmacy.** A pharmacy performing centralized pharmacy services. (7-1-13)
- 11. Centralized Pharmacy Services.** The processing by a central drug outlet or central pharmacist of a request from another pharmacy to fill, refill, or dispense a prescription drug order, perform processing functions, or provide cognitive or pharmaceutical care services. Each function may be performed by the same or different persons and at the same or different locations. (7-1-13)
- 12. Change of Ownership.** A change of majority ownership or controlling interest of a drug outlet licensed or registered by the Board. (3-21-12)
- 13. Charitable Clinic or Center -- Authorized Personnel.** A person designated in writing and authorized by the qualifying charitable clinic or center's medical director or consultant pharmacist to perform specified duties within the charitable clinic or center under the supervision of a pharmacist, physician, dentist, optometrist, physician assistant, or an advanced practice professional nurse with prescriptive authority. (3-21-12)
- 14. Chart Order.** A lawful drug order for a drug or device entered on the chart or a medical record of an inpatient or resident of an institutional facility. (3-21-12)
- 15. CME.** Continuing medical education. (3-21-12)
- 16. COE -- Central Order Entry.** A pharmacy that processes information related to the practice of pharmacy, engages solely in centralized prescription processing but from which drugs are not dispensed, is physically located outside the institutional pharmacy of a hospital, and is part of a hospital system. (3-21-12)
- 17. Collaborative Pharmacy Practice.** A pharmacy practice whereby one (1) or more pharmacists jointly agree to work under a protocol authorized by one (1) or more prescribers to provide patient care and DTM services not otherwise permitted to be performed by a pharmacist under specified conditions or limitations. (3-21-12)
- 18. Collaborative Pharmacy Practice Agreement.** A written agreement between one (1) or more pharmacists and one (1) or more prescribers that provides for collaborative pharmacy practice. (3-21-12)
- 19. Continuous Quality Improvement Program.** A system of standards and procedures to identify and evaluate quality-related events and to constantly enhance the efficiency and effectiveness of the structures and processes of a pharmacy system. (3-21-12)

20. **Correctional Facility.** Any place used for the confinement of persons charged with or convicted of an offense or otherwise confined under a court order. (4-4-13)
21. **CPE.** Continuing pharmacy education. (3-21-12)
22. **DEA.** United States Drug Enforcement Administration. (3-21-12)
23. **Distributor.** A supplier of drugs manufactured, produced, or prepared by others to persons other than the ultimate consumer. (3-21-12)
24. **DME.** Durable medical equipment. (3-21-12)
25. **Drug Order.** A prescription drug order issued in the unique form and manner permitted for a patient or resident of an institutional facility or as permitted for other purposes by these rules. Unless specifically differentiated, rules applicable to a prescription drug order are also applicable to a drug order. (3-21-12)
26. **Drug Product Selection.** The act of selecting either a brand name drug product or its therapeutically equivalent generic. (3-21-12)
27. **Drug Product Substitution.** Dispensing a drug product other than prescribed. (4-4-13)
28. **DTM -- Drug Therapy Management.** Selecting, initiating, or modifying drug treatment pursuant to a collaborative practice agreement. (3-21-12)
29. **Emergency Drugs.** Drugs required to meet the immediate therapeutic needs of one (1) or more patients that are not available from any other authorized source in sufficient time to avoid risk of harm due to the delay that would result from obtaining the drugs from another source. (3-21-12)
30. **Executive Director.** The Idaho State Board of Pharmacy executive director created by Sections 54-1713 and 54-1714, Idaho Code. (3-21-12)
31. **FDA.** United States Food and Drug Administration. (3-21-12)
32. **Flavoring Agent.** An additive used in food or drugs when the additive is used in accordance with the principles of good pharmacy practices and in the minimum quantity required to produce its intended effect. (3-21-12)
33. **Floor Stock.** Drugs or devices not labeled for a specific patient that are maintained at a nursing station or other department of an institutional facility, excluding the pharmacy, for the purpose of administering to patients of the facility. (3-21-12)
34. **FPGEC.** Foreign Pharmacy Graduate Examination Committee. (4-4-13)
35. **Hazardous Drug.** Any drug listed as such by the National Institute for Occupational Safety and Health or any drug identified by at least one (1) of the following criteria: ()
- a. **Carcinogenicity:** ()
- b. **Teratogenicity or developmental toxicity:** ()
- c. **Reproductive toxicity in humans:** ()
- d. **Organ toxicity at low doses in humans or animals:** ()
- e. **Genotoxicity:** or ()
- f. **New drugs that mimic existing hazardous drugs in structure or toxicity.** ()

~~356~~. **HIPAA.** Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). (3-21-12)

~~367~~. **Hospital System.** A hospital or hospitals and at least one (1) on-site institutional pharmacy under common ownership. A hospital system may also include one (1) or more COE pharmacies under common ownership. (3-21-12)

~~378~~. **Idaho State Board of Pharmacy or Idaho Board of Pharmacy.** The terms Idaho State Board of Pharmacy, Idaho Board of Pharmacy, State Board of Pharmacy, and Board of Pharmacy are deemed synonymous and are used interchangeably to describe the entity created under the authority of Title 54, Chapter 17, Idaho Code. Unless specifically differentiated, “the Board” or “Board” also means the Idaho State Board of Pharmacy. (3-21-12)

~~389~~. **Individually Identifiable Health Information.** Information that is a subset of health information, including demographic information, collected from an individual and that: (3-21-12)

a. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (3-21-12)

b. Relates to the past, present, or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to an individual that: (3-21-12)

i. Identifies the individual; or (3-21-12)

ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual. (3-21-12)

~~3940~~. **Institutional Pharmacy.** A pharmacy located in an institutional facility. (3-21-12)

~~401~~. **Interchangeable Biosimilar.** A licensed biosimilar product determined by the FDA to be therapeutically equivalent to the reference biological product and published in the Purple Book. (4-11-15)

(BREAK IN CONTINUITY OF SECTIONS)

012. DEFINITIONS AND ABBREVIATIONS (S -- Z).

01. Sample. A unit of a drug that is not intended to be sold and is intended to promote the sale of the drug. (3-21-12)

02. Secured Pharmacy. The area of a drug outlet where prescription drugs are prepared, compounded, distributed, dispensed, or stored. (3-21-12)

03. Skilled Nursing Facility. An institutional facility or a distinct part of an institutional facility that is primarily engaged in providing daily skilled nursing care and related services. (3-21-12)

04. Student Pharmacist. A term inclusive of pharmacist intern and pharmacist extern if differentiation is not needed. (3-21-12)

05. Technician. Unless specifically differentiated, a term inclusive of pharmacy technician, certified pharmacy technician, and technician-in-training to indicate an individual authorized by registration with the Board to perform routine pharmacy support services under the supervision of a pharmacist. (3-21-12)

06. Telepharmacy. The use of telecommunications and information technologies in the practice of pharmacy to provide pharmaceutical care services to patients at a distance. (3-21-12)

07. Therapeutic Equivalent Drugs. Products assigned an “A” code by the FDA in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) and animal drug products published in the FDA Approved Animal Drug Products (Green Book). (4-4-13)

08. Unit Dose. Drugs packaged in individual, sealed doses with tamper-evident packaging (for example, single unit-of-use, blister packaging, unused injectable vials, and ampules). (3-21-12)

09. USP. United States Pharmacopeia. (3-21-12)

10. USP-NF. United State Pharmacopeia-National Formulary. (3-21-12)

11. USP 795. The current edition of the United States Pharmacopeia-National Formulary, Chapter 795. ()

12. USP 797. The current edition of the United States Pharmacopeia-National Formulary, Chapter 797. ()

~~13.~~ VAWD -- Verified Accredited Wholesale Distributor. An accreditation program for wholesale distributors offered through NABP. (3-21-12)

~~14.~~ VDO -- Veterinary Drug Outlet. A registered establishment that employs a qualified VDT to distribute prescription veterinary drugs pursuant to lawful orders of a veterinarian. (3-21-12)

~~15.~~ VDT -- Veterinary Drug Technician. A non-pharmacist qualified by registration with the Board to distribute prescription veterinary drugs in a VDO. (3-21-12)

~~16.~~ Veterinary Drug Order. A lawful order by a veterinarian issued pursuant to the establishment of a veterinarian-patient-client relationship as recognized by the American Veterinary Medical Association. (3-21-12)

~~17.~~ VIS. Vaccine Information Statement. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

239. COMPOUNDING DRUG PRODUCTS.
Any compounding that is not permitted herein is considered manufacturing. (4-11-15)

01. Application. This rule applies to any person, including any business entity, authorized to engage in the practice of non-sterile compounding, sterile compounding, and sterile prepackaging of drug products in or into Idaho, except these rules do not apply to: (4-11-15)

a. Compound positron emission tomography drugs; (4-11-15)

b. Radiopharmaceuticals; (4-11-15)

c. The reconstitution of a non-sterile drug or a sterile drug for immediate administration; ~~and~~ (4-11-15)()

d. The addition of a flavoring agent to a drug product; ~~and~~ (4-11-15)()

e. Product preparation of a non-sterile, non-hazardous drug according to the manufacturer's FDA approved labeling. ()

02. General Compounding Standards. (4-11-15)

a. Active Pharmaceutical Ingredients. All active pharmaceutical ingredients must be obtained from an

FDA registered manufacturer. FDA registration as a foreign manufacturer satisfies this requirement. (4-11-15)

b. Certificate of Analysis. Unless the active pharmaceutical ingredient complies with the standards of an applicable USP-NF monograph, a CO must be obtained for all active pharmaceutical ingredients procured for compounding and retained for a period of not less than three (3) years from the date the container is emptied, expired, returned, or disposed of. The following minimum information is required on the COA: (4-11-15)

i. Product name; (4-11-15)

ii. Lot number; (4-11-15)

iii. Expiration date; and (4-11-15)

iv. Assay. (4-11-15)

c. Equipment. Equipment and utensils must be of suitable design and composition and cleaned, sanitized, or sterilized as appropriate prior to use. (4-11-15)

d. Disposal of Compromised Drugs. When the correct identity, purity, strength, and sterility of ingredients and components cannot be confirmed (in cases of, for example, unlabeled syringes, opened ampoules, punctured stoppers of vials and bags, and containers of ingredients with incomplete labeling) or when the ingredients and components do not possess the expected appearance, aroma, and texture, they must be removed from stock and isolated for return, reclamation, or destruction. (4-11-15)

03. Prohibited Compounding. Compounding any drug product for human use that the FDA has identified as presenting demonstrable difficulties in compounding or has withdrawn or removed from the market for safety or efficacy reasons is prohibited. (4-11-15)

04. Limited Compounding. (4-11-15)

a. Triad Relationship. A pharmacist may compound a drug product in the usual course of professional practice for an individual patient pursuant to an established prescriber/patient/pharmacist relationship and a valid prescription drug order. (4-11-15)

b. Commercially Available Products. A drug product that is commercially available may only be compounded if not compounded regularly or in inordinate amounts and if: (4-11-15)

i. It is medically warranted to provide an alternate ingredient, dosage form, or strength of significance; or (4-11-15)

ii. The commercial product is not reasonably available in the market in time to meet the patient's needs. (4-11-15)

c. Anticipatory Compounding. Limited quantities of a drug product may be compounded or sterile prepackaged prior to receiving a valid prescription drug order based on a history of receiving valid prescription drug orders for the compounded or sterile prepackaged drug product. (4-11-15)

05. Drug Compounding Controls. (4-11-15)

a. Policies and Procedures. In consideration of the applicable provisions of USP 795 concerning pharmacy compounding of non-sterile preparations, USP 797 concerning sterile preparations, Chapter 1075 of the USP-NF concerning good compounding practices, and Chapter 1160 of the USP-NF concerning pharmaceutical calculations, policies and procedures for the compounding or sterile prepackaging of drug products must ensure the safety, identity, strength, quality, and purity of the finished product, and must include any of the following that are applicable to the scope of compounding practice being performed: (4-11-15)

i. Appropriate packaging, handling, transport, and storage requirements; (4-11-15)

- ii. Accuracy and precision of calculations, measurements, and weighing; (4-11-15)
- iii. Determining ingredient identity, quality, and purity; (4-11-15)
- iv. Labeling accuracy and completeness; (4-11-15)
- v. Beyond use dating; (4-11-15)
- vi. Auditing for deficiencies, including routine environmental sampling, quality and accuracy testing, and maintaining inspection and testing records; (4-11-15)
- vii. Maintaining environmental quality control; and (4-11-15)
- viii. Safe limits and ranges for strength of ingredients, pH, bacterial endotoxins, and particulate matter. (4-11-15)

b. Accuracy. Components including, but not limited to, bulk drug substances, used in the compounding or sterile prepackaging of drug products must be accurately weighed, measured, or subdivided, as appropriate. The amount of each active ingredient contained within a compounded drug product must not vary from the labeled potency by more than the drug product's acceptable potency range listed in the USP-NF monograph for that product. If USP-NF does not publish a range for a particular drug product, the active ingredients must not contain less than ninety percent (90%) and not more than one hundred ten percent (110%) of the potency stated on the label. (4-11-15)

c. Non-Patient Specific Records. Except for drug products that are being compounded or sterile prepackaged for direct administration, a production record of drug products compounded or sterile prepackaged in anticipation of receiving prescription drug orders or distributed in the absence of a patient specific prescription drug order ("office use") solely as permitted in these rules, must be prepared and kept for each drug product prepared, including: (4-11-15)

- i. Production date; (4-11-15)
- ii. Beyond use date; (4-11-15)
- iii. List and quantity of each ingredient; (4-11-15)
- iv. Internal control or serial number; and (4-11-15)
- v. Initials or unique identifier of all persons involved in the process or the compounder responsible for the accuracy of these processes. (4-11-15)

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1504

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

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

The changes remove the requirement that the Board approve a temporary pharmacy facility or mobile pharmacy prior to operation in a declared emergency. It also clarifies that a hospital director may oversee a temporary pharmacy in an emergency. In addition, it removes the requirement that a statewide protocol be in place prior to emergency refill authorization being permissible in a declared emergency. Lastly, minor edits are made to collaborative pharmacy practice agreements with prescribers, clarifying the parties to these voluntary agreements, and harmonizing the record-keeping requirements with existing state law.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 497 through 501](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Alex Adams, Executive Director, at (208) 334-2356.

DATED this 3rd Day of November 2015.

Alex Adams
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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 docket adds missing or incomplete language allowing for statewide protocols. In the event of a federal or state declared emergency, new language would allow a pharmacist to perform drug therapy management as well as other patient care services according to statewide protocol in conjunction with the Board of Pharmacy and the Idaho Department of Health and Welfare. In addition, changes would allow for the suspension of requirements for those engaged in the scope of practice for which they are licensed in another state. New language would also allow for temporary pharmacies as well as mobile pharmacies and requirements therefor. Changes also provide that a pharmacist be allowed to refill prescriptions essential to the patients' health or continuation of therapy.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

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 under Docket No. 27-0101-1501 in the July 1, 2015 Idaho Administrative Bulletin, **Vol. 15-7, page 71** and in the August 5, 2015 Idaho Administrative Bulletin, **Vol. 15-8, page 106**.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams, Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September 2015.

LSO Rules Analysis Memo

Italicized red text that is **double underscored** is new text that has been added to the pending rule.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1504

016. BOARD OF PHARMACY LICENSURE AND REGISTRATION.

The Board is responsible for the control and regulation of the practice of pharmacy in or into the state of Idaho, which includes the licensure or registration of professional, supportive, and ancillary personnel who engage in or support the practice. The Board is also responsible for the control, regulation, and registration of persons or drug outlets that manufacture, distribute, or dispense controlled substances within or into the state. Licenses or registrations required by state or federal law, or both, must be obtained prior to engaging in these practices or their supportive functions, except that the Board may suspend such requirements for the duration of a national, state or local emergency declared by the President of the United States, the Governor of the State of Idaho, or by any other person with legal authority to declare an emergency, for individuals engaged in the scope of practice for which they are licensed in another state. (3-21-12)()

01. Pharmacy Practice Act Licenses and Registrations. The Board will issue or renew a license or a certificate of registration upon application and determination that the applicant has satisfied the requirements of the Idaho Pharmacy Act and any additional criteria specified by these rules for the license or registration classification. Licenses and certificates of registration issued pursuant to Title 54, Chapter 17, Idaho Code, expire annually on June 30 unless an alternate expiration term or date is specifically stated in these rules. (3-21-12)

02. Idaho Controlled Substances Act Registrations. The Board will issue or renew controlled substance registrations upon application and determination that the applicant has satisfied the requirements of the Idaho Controlled Substances Act and any additional criteria specified by state or federal law applicable to applicants that manufacture, distribute, or dispense, or conduct research with, controlled substances. Registrations issued pursuant to Title 37, Chapter 27, Idaho Code, must be renewed annually by June 30 for pharmacists and by December 31 for all other registrants. (4-4-13)

a. Unless a wholesaler, an applicant for an Idaho controlled substance registration must hold a valid, unrestricted Idaho license to prescribe, dispense, or administer controlled substances and, unless a pharmacist or certified euthanasia technician, a valid federal DEA registration. If a required license or registration is cancelled or otherwise invalidated by the issuing agency, the Idaho controlled substance registration will be correspondingly cancelled. (3-21-12)

b. A registrant engaging in more than one (1) group of independent activities, as defined by federal law, must obtain a separate Idaho controlled substance registration for each group of activities if not exempted from separate DEA registration by federal law. (3-21-12)

(BREAK IN CONTINUITY OF SECTIONS)

060. DRUG OUTLET LICENSURE AND REGISTRATION.

A license or a certificate of registration, as applicable, is required for drug outlets doing business in or into Idaho. A license or certificate of registration will be issued by the Board to drug outlets pursuant to, and in the general classifications defined by, Section 54-1729, Idaho Code. (3-21-12)

01. New Drug Outlet Inspections. Prior to approving the issuance of a new license or registration, each drug outlet may be inspected to confirm that the facility is appropriately equipped and has implemented proper procedures and minimum standards necessary for compliance with applicable law. Prescription drugs may not be delivered to a new drug outlet location and the drug outlet may not open for business prior to satisfactory completion of the opening inspection, if required. (3-21-12)

02. Licenses and Registrations ~~Nontransferable~~ Transferability. ()

a. Licenses and Registrations Nontransferable. Drug outlet licenses and registrations are location specific and are nontransferable as to person or place, except in the event of a national, state, or local emergency declared by the President of the United States, the Governor of the State of Idaho, or by any other person with legal authority to declare an emergency. If the ownership or location of an outlet changes, any registration or license issued to it by the Board is void. (3-21-12)()

b. Temporary Pharmacy Facilities and Mobile Pharmacies. To provide pharmacy services during a

national, state, or local emergency declared by the President of the United States, the Governor of the State of Idaho, or by any other person with legal authority to declare an emergency, pharmacies may arrange to temporarily locate or relocate to a temporary pharmacy facility or mobile pharmacy if the temporary pharmacy facility or mobile pharmacy: ()

i. Is under the control and management of the pharmacist-in-charge, director, or designated supervising pharmacist: ()

ii. Is located within the declared disaster area or is intended for affected populations: ()

iii. Notifies the Board of its proposed location: ()

iv. Is properly secured to prevent theft and diversion of drugs: ()

v. Maintains records in accordance with laws and rules of the state; and ()

vi. Ceases the provision of services with the termination of the declared emergency, or as otherwise authorized by the Board. ()

03. Nonresident Drug Outlet. The Board may license or register a drug outlet licensed or registered under the laws of another state if the other state's standards are comparable to those in Idaho and acceptable to the Board, evidenced by an inspection report. (7-1-13)

(BREAK IN CONTINUITY OF SECTIONS)

116. PRESCRIPTION DRUG ORDER: REFILLS.

01. Refill Authorization. A prescription drug order may be refilled when permitted by state and federal laws and only as specifically authorized by the prescriber. (3-21-12)

a. A pharmacist, utilizing his best professional judgment, may dispense a prescription drug that is not a controlled substance up to the total amount authorized by the prescriber including refills. (3-21-12)

b. Refills exceeding those authorized by the prescriber on the original prescription drug order may only be authorized through issuance of a new and separate prescription drug order. (3-21-12)

02. Emergency Prescription Refills. A pharmacist may refill a prescription for a patient when: ()

a. The prescriber is not available for authorization if, in the professional judgment of the pharmacist, a situation exists that threatens the health or safety of the patient should the prescription not be refilled. Only sufficient medication may be provided, consistent with the dosage instructions, to maintain the prescribed treatment until, at the earliest possible opportunity, the issuing or an alternative prescriber is contacted for further renewal instructions. (3-21-12)()

b. Upon the declaration of a national, state, or local emergency by the President of the United States, the Governor of the State of Idaho, or by any other person with legal authority to declare an emergency, a pharmacist may dispense a refill of a prescription drug to an affected patient, not to exceed a thirty (30)-day supply if, in the pharmacist's professional judgment, the prescription drug is essential to the patient's health or continuation of therapy. ()

(BREAK IN CONTINUITY OF SECTIONS)

310. ~~PHARMACIST~~ COLLABORATIVE PHARMACY PRACTICE AND STATEWIDE PROTOCOL AGREEMENTS.

01. Collaborative Agreement. Pharmacists or pharmacies and prescribers may enter into collaborative pharmacy practice through a written collaborative pharmacy practice agreement that defines the nature and scope of authorized DTM or other patient care services to be provided by a pharmacist. (3-21-12)()

- 01a.** Agreement Elements. The collaborative pharmacy practice agreement must include: (3-21-12)
 - i.** Identification of the parties to the agreement; (3-21-12)
 - ii.** The establishment of each pharmacist's scope of practice authorized by the agreement, including a description of the types of permitted activities and decisions; (3-21-12)
 - iii.** The drug name, class, or category and protocol, formulary, or clinical guidelines that describe or limit a pharmacist's authority to perform DTM; (3-21-12)
 - iv.** A described method for a prescriber to monitor compliance with the agreement and clinical outcomes of patients and to intercede where necessary; (3-21-12)
 - v.** A provision documenting a prescriber's right to override a collaborative practice decision made by a pharmacist whenever deemed necessary or appropriate; (3-21-12)
 - vi.** A provision allowing any party to cancel the agreement by written notification; (3-21-12)
 - vii.** An effective date; and (3-21-12)
 - viii.** Signatures of the parties to the agreement and dates of signing. (3-21-12)
- ix.** Amendments to a collaborative pharmacy practice agreement must be documented, signed, and dated. (3-21-12)
- 02b.** Board Review. The original collaborative pharmacy practice agreement and any subsequent revisions must be made available to the Board upon request. (3-21-12)
- 03c.** Agreement Review. The collaborative pharmacy practice agreement must be reviewed and renewed annually and revised when necessary or appropriate. (3-21-12)
- 04d.** Documentation of Pharmacist Activities. The patient care provided pursuant to the agreement must be documented in the patient's permanent record in a manner that allows it to be readily available to other healthcare professionals providing care to the patient. (3-21-12)()

02. Statewide Protocol Agreement. A pharmacist may perform DTM or other patient care services according to a statewide protocol agreement issued by the director of the Idaho Department of Health and Welfare, in conjunction with the Board, for the purpose of improving public health. The protocol agreement must include: ()

- a.** An effective date range; ()
- b.** The geographical portion of the state where the protocol agreement is to be effective; and ()
- c.** The drug name, class, or category and protocol, formulary or clinical guidelines that describe or limit a pharmacist's authority to perform DTM or other patient care services. ()

IDAPA 27 - BOARD OF PHARMACY

27.01.01 - RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1505

NOTICE OF RULEMAKING - ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2016 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-1717, Idaho Code.

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

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2015 Idaho Administrative Bulletin, [Vol. 15-10, pages 502 - 505](#).

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Alex Adams, Executive Director, at (208) 334-2356.

DATED this 3rd day of November 2015.

Alex Adams
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
P. O. Box 83720
Boise, ID 83720-0067
Phone: (208) 334-2356
Fax: (208) 334-3536

THE FOLLOWING NOTICE WAS PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 54-1717, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2015.

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 clarifies and adds missing language in definitions. The changes provide needed updating and additional language to definitions. Pharmaceutical Care Services is updated by adding the ability to order and interpret laboratory tests. Reconstitution definition is also added to provide clarification as to what is considered compounding as opposed to reconstitution of a drug.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

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

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 under Docket No. 27-0101-1501 in the July 1, 2015 Idaho Administrative Bulletin, **Vol. 15-7, page 71** and in the August 5, 2015 Idaho Administrative Bulletin, **Vol. 15-8, page 106**.

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: NA

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams, Executive Director, at (208) 334-2356.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2015.

DATED this 4th Day of September 2015.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1505

011. DEFINITIONS AND ABBREVIATIONS (J -- R).

01. LTCF -- Long-Term Care Facility. An institutional facility that provides extended health care to resident patients. (3-21-12)

02. Mail Service Pharmacy. A nonresident pharmacy that ships, mails, or delivers by any lawful means a dispensed legend drug to residents in this state pursuant to a legally issued prescription drug order and ensures the provision of corresponding related pharmaceutical care services required by law. (7-1-13)

03. MPJE. Multistate Pharmacy Jurisprudence Exam. (3-21-12)

04. MTM -- Medication Therapy Management. A distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision or administration of a drug or a device and encompass a broad range of activities and responsibilities. The MTM service model in pharmacy practice includes the following five core elements: (3-21-12)

a. Medication therapy review; (3-21-12)

- b.** Personal medication record; (3-21-12)
- c.** Medication-related action plan; (3-21-12)
- d.** Intervention or referral, or both; (3-21-12)
- e.** Documentation and follow-up. (3-21-12)
- 05.** **NABP.** National Association of Boards of Pharmacy. (3-21-12)
- 06.** **NAPLEX.** North American Pharmacists Licensure Examination. (3-21-12)
- 07.** **NDC.** National Drug Code. (3-21-12)
- 08.** **Non-Institutional Pharmacy.** A pharmacy located in a drug outlet that is not an institutional facility. (3-21-12)
- 09.** **Outsourcing Drug Outlet.** A drug outlet that is registered by the United States Food and Drug Administration pursuant to 21 U.S.C. Section 353b and either registered or endorsed by the Board. (4-6-15)
- 10.** **Parenteral Admixture.** The preparation and labeling of sterile products intended for administration by injection. (3-21-12)
- 11.** **Pharmaceutical Care Services.** A broad range of pharmacist-provided cognitive services, activities and responsibilities intended to optimize drug-related therapeutic outcomes for patients. Pharmaceutical care services may be performed independent of, or concurrently with, the dispensing or administration of a drug or device and encompasses services provided by way of DTM under a collaborative practice agreement, pharmacotherapy, clinical pharmacy practice, pharmacist independent practice, and MTM. Except as permitted pursuant to a collaborative practice agreement, nothing in these rules allows a pharmacist, beyond what is statutorily allowed, to engage in the unlicensed practice of medicine or to diagnose, prescribe, or conduct physical examinations. Pharmaceutical care services are not limited to, but may include one (1) or more of the following, according to the individual needs of the patient: (4-4-13)

 - a.** Performing or obtaining necessary assessments of the patient's health status, including the performance of health screening activities that may include, but are not limited to, obtaining finger-stick blood samples; (3-21-12)
 - b.** Reviewing, analyzing, evaluating, formulating or providing a drug utilization plan; (3-21-12)
 - c.** Monitoring and evaluating the patient's response to drug therapy, including safety and effectiveness; (3-21-12)
 - d.** Performing a comprehensive drug review to identify, resolve, and prevent drug-related problems, including adverse drug events; (3-21-12)
 - e.** Documenting the care delivered; (3-21-12)
 - f.** Communicating essential information or referring the patient when necessary or appropriate; (3-21-12)
 - g.** Providing counseling education, information, support services, and resources applicable to a drug, disease state, or a related condition or designed to enhance patient compliance with therapeutic regimens; (3-21-12)
 - h.** Conducting a drug therapy review consultation with the patient or caregiver; (3-21-12)
 - i.** Preparing or providing information as part of a personal health record; (3-21-12)

- j. Identifying processes to improve continuity of care and patient outcomes; (3-21-12)
- k. Providing consultative drug-related intervention and referral services; (3-21-12)
- l. Coordinating and integrating pharmaceutical care services within the broader health care management services being provided to the patient; ~~and~~ ~~(3-21-12)~~ ()
- ~~m.~~ Ordering and interpreting laboratory tests; and ()
- ~~n.~~ Other services as allowed by law. (3-21-12)
- 12. **Pharmacist Extern.** A person enrolled in an accredited school or college of pharmacy who is pursuing a professional degree in pharmacy. (4-4-13)
- 13. **Pharmacist Intern.** A person who has successfully completed a course of study at an accredited school or college of pharmacy, has received a professional degree in pharmacy, and is obtaining practical experience under the supervision of a pharmacist. (3-21-12)
- 14. **Pharmacy Operations.** Activities related to and including the preparation, compounding, distributing, or dispensing of drugs or devices from a pharmacy. (3-21-12)
- 15. **PHI -- Protected Health Information.** Individually identifiable health information that is: (3-21-12)
 - a. Transmitted by electronic media (as defined by the HIPAA Privacy Rule at 45 CFR 160.103); (3-21-12)
 - b. Maintained in electronic media; and (3-21-12)
 - c. Transmitted or maintained in any other form or medium. (3-21-12)
 - d. PHI excludes individually identifiable health information in:
 - i. Education records covered by the Family Education Right and Privacy Act, as amended (20 U.S.C. Section 1232g); (3-21-12)
 - ii. Records described at 20 U.S.C. Section 1232g(a)(4)(B)(iv); and (3-21-12)
 - iii. Employment records held by a covered entity (as defined by the HIPAA Privacy Rule at 45 CFR 160.103) in its role as an employer. (3-21-12)
- 16. **PIC.** Pharmacist-in-charge. (3-21-12)
- 17. **PMP.** Prescription Monitoring Program. (3-21-12)
- 18. **Prepackaging.** The act of transferring a drug, manually or using an automated system, from a manufacturer's original container to another container prior to receiving a prescription drug order. (3-21-12)
- 19. **Prescriber.** An individual currently licensed, registered, or otherwise authorized to prescribe and administer drugs in the course of professional practice. (3-21-12)
- 20. **Prescriber Drug Outlet.** A drug outlet in which prescription drugs or devices are dispensed directly to patients under the supervision of a prescriber, except where delivery is accomplished only through on-site administration or the provision of drug samples. (3-21-12)
- 21. **Purple Book.** The list of licensed biological products with reference product exclusivity and

biosimilarity or interchangeability evaluations published by the FDA under the Public Health Service Act. (4-11-15)

22. Readily Retrievable. Records are considered readily retrievable if they are able to be completely and legibly produced upon request within seventy-two (72) hours. (3-21-12)

23. Reconstitution. The process of adding a diluent to a powdered medication to prepare a solution or suspension, according to the product's labeling or the manufacturer's instructions. ()

24. Relative Contraindication. A condition that renders a particular treatment or procedure inadvisable, but not prohibitive. (3-21-12)

25. Remote Dispensing Site. A licensed pharmacy staffed by one or more certified technicians at which telepharmacy services are provided through a supervising pharmacy. (3-21-12)

26. Remote Office Location. A secured area that is restricted to authorized personnel, adequately protects private health information, and shares a secure common electronic file or a private, encrypted connection with a pharmacy, from which a pharmacist who is contracted or employed by a central drug outlet performs centralized pharmacy services. (7-1-13)

27. Retail Non-Pharmacy Drug Outlet. A retail outlet that sells non-prescription drugs or devices that is not a pharmacy. (3-21-12)

28. Retail Pharmacy. A community or other pharmacy that sells prescription drugs at retail and is open to the public for business. (3-21-12)

29. R.N. Registered nurse. (3-21-12)