PENDING RULES

COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

House Health & Welfare Committee

64th Idaho Legislature
Second Regular Session – 2018

Prepared by:

Office of the Administrative Rules Coordinator
Department of Administration

January 2018

HOUSE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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15.01.03 – RULES GOVERNING THE OMBUDSMAN FOR THE ELDERLY PROGRAM

DOCKET NO. 15-0103-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 67-5003(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:

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 6, 2017 Idaho Administrative Bulletin, **Vol. 17-9, pages 86 through 92**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cathy Hart at (208) 577-2855.

DATED this 29th day of September, 2017.

Cathy Hart
State Ombudsman
Commission on Aging
341 W. Washington Street
Boise, ID 83702
Phone: (208) 577-2855
Fax: (208) 334-3033

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-5003(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 20, 2017.

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 amends terminology and complaint processing procedures to better reflect existing practices and the intent of the Older Americans Act. It also clarifies that disclosure of records must conform with the Older Americans Act. The changes revise the term 'substate ombudsman' to 'local ombudsman' to conform with applicable state statutes and common usage; clarify times at which the ombudsman shall have access to certain facilities for purposes of investigations; clarify that a facility's release of resident information to the ombudsman for investigation purposes does not violate HIPAA; and clarify that the disclosure of ombudsman records must be consistent with the Older Americans Act.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible. The changes being made are driven primarily by the requirement to conform with federal law, as established by the Older Americans Act.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cathy Hart at (208) 577-2855

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 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 15-0103-1701

010. DEFINITIONS.
Any item not specifically defined below shall have the same meaning as those defined in IDAPA 15.01.01, "Rules Governing Senior Services Program," and the Older Americans Act (OAA), Section 711, and Title 67, Chapter 50, Idaho Code. (7-1-98)

01. Access. Right to enter long-term care facility upon notification of person in charge. (7-1-98)

02. Affected Parties. Long-term care facilities, state or county departments or agencies, or others against whom a complaint has been lodged. (7-1-98)

03. Area III. Planning and service area made up of: Canyon, Valley, Boise, Gem, Elmore, Washington, Ada, Adams, Payette, and Owyhee counties. (7-1-98)

04. Complainant. The ~~*substate*~~ local ombudsman or any individual or organization who registers a complaint with the ~~*substate*~~ local ombudsman. ~~(7-1-98)~~( )

05. Complaint Investigation/Resolution. Activities related to receiving, analyzing, researching, observing, interviewing, verifying or resolving a complaint through advocacy, facilitation, conciliation, mediation, negotiation, representation, referral, follow-up, or education. (7-1-98)

06. Complaints. Allegations made by or on behalf of eligible clients, whether living in long-term care facilities or in the community. (7-1-98)

07. Designation. Process by which the Office approves the location of ~~*substate*~~ local ombudsman programs within AAAs and delegates to such programs the authority to carry out the purposes of the program. ~~(7-1-98)~~( )

~~*12*~~08. ~~*Substate*~~ Local **Ombudsman**. An individual associated with a designated local Ombudsman for the Elderly Program, who performs the duties of ombudsman. ~~(7-1-98)~~( )

~~*1*~~09. **Long-Term Care Facility**. Skilled nursing facilities as defined in IDAPA 16.03.02, Subsection 002.33, "Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities," and residential care facilities as defined in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (7-1-98)

10~~*8*~~. **Non-Jurisdictional Complaints**. Complaints made by or on behalf of residents of long-term care facilities who are under the age of sixty (60) or complaints concerning persons outside the statutory jurisdiction of an ombudsman. (7-1-98)

~~*09*~~11. **Office**. Office of the State Ombudsman for the Elderly pursuant to Title 67, Chapter 50, Idaho Code, Section 67-5009. (7-1-98)

1~~*1*~~2. **Resident**. Resident as defined in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (7-1-98)

011. -- 019. (RESERVED)

020. ADMINISTRATIVE REQUIREMENTS.
Each AAA ~~*substate*~~ local ombudsman program shall meet all administrative requirements as cited in OAA, Section 712 (a), and Title 67, Chapter 50, Idaho Code, Section 67-5009, unless granted a waiver by the ~~*ICOA*~~ Office. ~~(7-1-98)~~( )

01. Procedures. All ~~*substate*~~ local ombudsmen shall follow procedures outlined in the ~~*Ombudsman for the Elderly*~~ Office Procedures Manual. ~~*(7-1-98)*~~( )

02. Space. Each AAA shall provide space assuring privacy for ~~*substate*~~ local ombudsmen to hold confidential meetings. ~~*(7-1-98)*~~( )

03. Supervision. ~~*Substate*~~ Local ombudsmen shall operate under the direct supervision of the Office for all complaint handling activities and are considered subdivisions of the Office. ~~*(7-1-98)*~~( )

04. Forms. All ~~*substate*~~ local ombudsmen shall utilize standardized forms provided by the Office. ~~*(7-1-98)*~~( )

05. Conflict of Interest. AAAs shall ensure that the ~~*substate*~~ local ombudsmen shall not be part of an organization that: ~~*(7-1-98)*~~( )

a. Is responsible for licensing and certifying skilled nursing or residential care facilities under IDAPA 16.03.22, "Rules for Licensed Residential and Assisted Living Facilities in Idaho"; (7-1-98)

b. Provides skilled nursing or living care or is an association of such a provider; or (7-1-98)

c. May impair the ability of the ~~*substate*~~ local ombudsmen to investigate and resolve complaints objectively and independently. ~~*(7-1-98)*~~( )

06. Travel Funds. Each AAA shall provide travel funds for the ~~*substate*~~ local ombudsman program to carry out activities related to complaint investigations. ~~*(7-1-98)*~~( )

07. Program Report. All ~~*substate*~~ local ombudsman programs shall comply with ~~*ICOA's*~~ the Office's reporting requirements. ~~*(7-1-98)*~~( )

08. Program Reviews. Each AAA shall submit to a program review of ~~*substate*~~ local ombudsman programs at reasonable intervals deemed necessary by the ~~*ICOA*~~ Office. ~~*(7-1-98)*~~( )

09. Adult Protection and Ombudsman Coordination. Each AAA shall ensure that Adult Protection staff and the ~~*substate*~~ local ombudsman maintain a written agreement establishing cooperative protocols in the investigation of complaints. ~~*(7-1-98)*~~( )

10. State Agreements. All ~~*substate*~~ local programs shall honor and carry out state-level agreements between the Office and other agencies of government. ~~*(7-1-98)*~~( )

021. STAFFING.
Pursuant to the OAA, Section 712, in order to meet minimum requirements established for the position of ~~*substate*~~ local ombudsman, each AAA shall seek applicants having the following qualifications. ~~*(7-1-98)*~~( )

01. Minimum Qualifications. Any person hired to fill the position of ~~*substate*~~ local ombudsman on or after July 1, 1998, shall have: ~~*(7-1-99)*~~( )

a. A Bachelor's degree or equivalent; (3-30-01)

b. Minimum of one (1) year's experience working with the elderly; (7-1-98)

c. Ability to effectively communicate verbally and in writing; (7-1-98)

d. Knowledge of long-term care issues and resources; (7-1-98)

e. Demonstrated ability to interpret and apply relevant local, state and federal laws, rules, regulations, and guidelines; (7-1-98)

f. Demonstrated ability to work independently; (7-1-98)

g. Demonstrated skill in interviewing techniques; and (7-1-98)

h. Demonstrated ability to collect data, conduct interviews and to form conclusions. (7-1-98)

02. Hiring. The Office shall be included in the process of interviewing and selecting applicants for the ~~substate~~ local ombudsman position. The AAA shall make the final selection from the top three (3) applicants. ~~(7-1-98)~~( )

022. -- 030. (RESERVED)

031. DESIGNATION OF AUTHORITY OF AAA.
The Office shall designate an entity as a ~~substate~~ local ombudsman. ~~(7-1-98)~~( )

01. Designation of Authority. Each AAA shall directly provide, through a contract agreement with the ICOA, a ~~substate~~ local ombudsman program employing at least one (1) full-time ~~substate~~ local ombudsman whose function shall be to carry out the duties of the ~~Ombudsman for the Elderly Program~~ Office. AAAs I, II, IV, V and VI shall employ one (1) full-time ~~substate~~ local ombudsman; AAA III shall employ two (2) full-time ~~substate~~ local ombudsmen. An AAA may petition ~~ICOA~~ the Office in writing for a waiver of this requirement. ~~(7-1-98)~~( )

02. Grounds for Revocation or Termination. In revoking a designated ~~substate~~ local ombudsman program, the ~~ICOA~~ Office shall provide due process in accordance with applicable law and IDAPA 04.11.01, Section 000, et seq., "Idaho Rules of Administrative Procedure of the Attorney General." ~~(7-1-98)~~( )

a. Following termination of a ~~substate~~ local ombudsman program, the ~~ICOA~~ Office shall perform the duties of the ~~substate~~ local program. ~~(7-1-98)~~( )

b. Following termination of a ~~substate~~ local ombudsman program, the ~~ICOA~~ Office shall withdraw funding for the ~~substate~~ local program for the remainder of the funding period. ~~(7-1-98)~~( )

c. An AAA's appeal of ~~ICOA's~~ the Office's termination of its ~~substate~~ local ombudsman program shall be governed by the Adjudicatory Rules of Practice and Procedures in Claims Relating to Contracts and Grants Funded under Title III, OAA. ~~(7-1-98)~~( )

032. HANDLING OF COMPLAINTS.
The ~~Ombudsman for the Elderly Program~~ Office has jurisdiction to accept, identify, investigate, and resolve complaints made by, or on behalf of, persons aged sixty (60) or older, living in the community or in long-term care facilities. The Office and the ~~substate~~ local ombudsmen shall ensure that persons aged sixty (60) or older have regular and timely access to services provided through the Office. The ~~Ombudsman for the Elderly Program~~ Office shall represent the interests of older persons before governmental agencies and shall seek to protect the health, safety, welfare and rights of older persons. ~~(7-1-98)~~( )

01. Non-Jurisdictional Complaints. ~~Substate~~ Local ombudsmen may respond to complaints made by or on behalf of under age sixty (60) long-term care residents where such action will: ~~(7-1-98)~~( )

a. Benefit other residents; or (7-1-98)

b. Provide the only viable avenue of assistance available to the complainant. (7-1-98)

02. Conflict of Interest. ~~Substate~~ Local ombudsmen shall refer to the Office any complaint involving AAA staff or contractors. ~~(7-1-98)~~( )

03. Complaints. Complaints concerning ~~substate~~ local ombudsmen, or relative to a ~~substate~~ local ombudsman's official duties, shall be directly referred to the ~~ICOA~~ Office. The ~~ICOA~~ Office, upon completing an investigation of such complaint, shall provide findings and recommendations to the AAA. ~~(7-1-98)~~( )

04. Guardianship. The ~~*substate*~~ local ombudsmen shall not serve as an ex-officio or appointed member of any Board of Community Guardian, nor file an affidavit to the court for guardianship. ~~*(7-1-99)*~~( )

05. Court Visitor. The ~~*substate*~~ local ombudsmen shall not act as court visitor in any guardianship/conservatorship proceeding concerning a past or current client. ~~*(7-1-98)*~~( )

06. Legal Documents. ~~*Substate*~~ Local ombudsmen shall not, in their capacity as ombudsmen, act as a notary or a witness of signatures for legal documents. ~~*(7-1-98)*~~( )

033. ACCESS.
The Office shall ensure that representatives of the Office have access to long-term care facilities and residents as well as appropriate access to medical and social records, and resident representative contact information needed to investigate complaints. ~~*(7-1-98)*~~( )

01. Visitation. For visitation purposes, ~~*substate*~~ local ombudsmen shall have access to long-term care facilities during regular business hours. Visiting ~~*substate*~~ local ombudsmen shall: ~~*(7-1-98)*~~( )

a. Notify the person in charge upon entering the facility; (7-1-98)

b. Be allowed to visit common areas of the facility and the rooms of residents if consent is given by the resident; and (7-1-99)

c. Communicate privately and without restriction with any resident who consents to the communication. (7-1-98)

02. Investigation. ~~*Substate*~~ Local ombudsmen shall have access to long-term care facilities at any time for the purpose of conducting investigations. A ~~*substate*~~ local ombudsman conducting an investigation shall: ~~*(7-1-98)*~~( )

a. Notify the person in charge upon entering the facility; (7-1-98)

b. Be allowed to visit common areas of the facility and the rooms of residents if consent is given by the resident; (7-1-98)

c. Seek out residents who consent to communicate privately; (7-1-98)

d. Communicate privately and without restriction with any resident who consents to the communication; and (7-1-98)

e. Inspect a resident's records under conditions set forth in the OAA, Section 712. (7-1-98)

f. Inspect facility administrative records, policies, and documents that are accessible to the resident and general public. ( )

03. Privacy. ~~*Substate*~~ Local ombudsmen shall have statutory authority to visit facilities and residents in facilities unescorted by facility personnel. See Section 67-5009, Idaho Code. ~~*(7-1-98)*~~( )

04. HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, 45 CFR 164, subparts A and E, does not preclude release by the facility of resident private health information or other resident identifying information to the Office. ( )

034. -- 040. (RESERVED)

041. WRITTEN CONSENT.
The Office shall ensure appropriate access to review medical and social records of a resident. (See OAA, Section 712) (7-1-98)

01. Resident Written Consent. Access to confidential records requires the written consent of the resident or legal representative. (7-1-98)

02. Lack of Consent. If the client is unable to provide written or oral consent, or the legal representative is unavailable to provide consent, the ~~substate~~ local ombudsman, with approval of the Office may inspect available client records, including medical records that are necessary for investigation of a complaint. ~~(7-1-98)~~( )

03. Consent Refused. If a ~~substate~~ local ombudsman has been refused access to records by legal representative but has reasonable cause to believe that the legal representative is not acting in the best interest of the client, the ~~substate~~ local ombudsman may, with the approval of the Office, inspect client records, including medical records. ~~(7-1-98)~~( )

04. Requirements for Informing Client or Resident. The ~~substate~~ local ombudsman shall inform the complainant or resident regarding: ~~(7-1-98)~~( )

a. Who will receive the information; (7-1-98)

b. What information will be disclosed; and (7-1-98)

c. The purpose for which the information is being disclosed. (7-1-98)

042. CONFIDENTIALITY.
The Office shall be the custodian of all ~~substate~~ local ombudsman program records including, but not limited to, records and files containing personal information relative to complainants and residents of long-term care facilities. Requests for release of confidential information shall be submitted to the Office for approval or denial. Release of information shall be granted pursuant to OAA, Section 721(e). ~~(7-1-98)~~( )

01. Storage of Records. Client records shall be maintained in locked storage. Case records inactive for two (2) years or longer may be expunged. As required by law, release of these records shall be limited to persons authorized by the Office. (7-1-98)

02. Performance Evaluations. For performance evaluation purposes, direct supervisors shall have access to client files maintained by ~~substate~~ local ombudsmen. ~~(7-1-98)~~( )

03. Confidential Records. Records to be safeguarded include, but are not limited to, long-term care and community-based complaint files including: (7-1-98)

a. Notes of interviews with complainants and clients or collateral contacts; (7-1-98)

b. All copies of residents' medical records or diagnoses; (7-1-98)

c. All records relevant to complaint investigations; (7-1-98)

d. All memoranda generated by the Office or by another agency office during the evaluation and resolution of a complaint; (7-1-98)

e. All photographs, video tapes, tape recordings, etc. pertaining to complaint investigation; (7-1-98)

f. All memoranda or letters generated during evaluation or resolution of a complaint; (7-1-98)

g. Written documentation that parties affected by ombudsman opinions or recommendations have been notified; and (7-1-98)

h. Information containing unverified complaints about long-term care facility owners, administrators, staff or other persons involved in the long-term care system or in other service programs. (7-1-98)

04. Request for Anonymity. The ombudsman shall honor a resident's or complainant's request to remain anonymous. If investigation of a complaint requires that a resident's or complainant's name be divulged in order for the investigation to proceed, the ombudsman shall so inform the resident or complainant. If the resident or complainant insists on maintaining anonymity, the ombudsman may terminate the investigation. (7-1-98)

043. DISCLOSURE.
The Office ~~*shall be*~~ is the only entity ~~*having authority to authorize disclosure of substate*~~ authorized to disclose ombudsmen program files, records, or information. ~~*maintained by the program except when the ICOA is subpoenaed by the court to disclose pertinent records*~~ Identifying information of any resident or complainant shall be disclosed only with proper consent or in response to a court order. The Office, in its sole discretion, may delegate the disclosure of ombudsman program files, records, or information to a local ombudsman. ~~*(7-1-98)*~~( )

01. Court Order. Identifying information of a resident, complainant, or both may be disclosed, with or without the consent of the resident, complainant, or both, pursuant to a court order issued by a court of competent jurisdiction. ( )

02. Resident Consent. Without a court order, identifying information of a resident shall be disclosed only if the resident or his representative communicates informed consent to the disclosure and the consent is given in writing, orally, visually or through the use of auxiliary aids and services; and such consent is documented by a representative of the Office in accordance with procedures. ( )

03. Complainant Consent. Without a court order, identifying information of a complainant shall be disclosed only if the complainant communicates informed consent to the disclosure and the consent is given in writing, orally, visually or through the use of auxiliary aids and services; and such consent is documented by a representative of the Office in accordance with procedures. ( )

044. -- 999. (RESERVED)

IDAPA 15 – OFFICE OF THE GOVERNOR
IDAHO COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

15.02.02 – VOCATIONAL REHABILITATION SERVICES

DOCKET NO. 15-0202-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 67-5407(e) and 67-5408, 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 6, 2017 Idaho Administrative Bulletin, **Vol. 17-9, pages 93 through 99**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mike Walsh at (208) 334-3220 ext. 110.

DATED this 29th day of September, 2017.

Mike Walsh
Rehabilitation Services Chief
Idaho Commission for the Blind and Visually Impaired
341 W. Washington Street
P. O. Box 83720
Boise, ID 83720-0012
Phone: (208) 334-3220 ext. 110
Fax: (208) 334-2963

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 67-5407(e) and 67-5408, 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 20, 2017.

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:

ICBVI must implement new rules in order to maintain compliance with the Workforce Innovation and Opportunity Act (WIOA) by establishing an order of selection for federal funds received through the agency. ICBVI is also adding a definition for "Most Significant Disability" and updating other rules.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the July 5, 2017 Idaho Administrative Bulletin, **Vol. 17-7, page 53**.

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:

On July 22, 2014, President Obama signed into law Public Law No. 113-128, the Workforce Innovation and Opportunity Act (WIOA). WIOA is the first legislative reform of the public workforce development system in more than 15 years. WIOA supersedes the Workforce Investment Act of 1998 (WIA). Title IV of WIOA includes amendments to the Rehabilitation Act of 1973, including amendments to Title I of the Rehabilitation Act, which authorizes funding for the State Vocational Rehabilitation (State VR) Program.

To implement the changes to the Rehabilitation Act made by WIOA, the Secretary of Education amends the regulations governing the State VR program [34 CFR part 361] and the State Supported Employment Services Program [34 CFR part 363], administered by the Rehabilitation Services Administration (RSA), within the Office of Special Education and Rehabilitative Services. In addition, the Secretary of Education issues regulations in new 34 CFR part 397 that implement Section 511 of the Rehabilitation Act (Limitations on Use of Subminimum Wages).

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mike Walsh at (208) 334-3220 ext. 110.

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 27, 2017.

DATED this 31st day of July, 2017.

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis

THE FOLLOWING IS THE TEXT OF DOCKET NO. 15-0202-1701

000. LEGAL AUTHORITY.
This chapter is adopted in accordance with Sections 67-5407(e) and 67-5408, Idaho Code, and the Rehabilitation Act of 1973, as amended. ~~(4-2-08)~~( )

001. TITLE AND SCOPE.
These rules will be known as Idaho Commission for the Blind and Visually Impaired Rules, IDAPA 15.02.02, "Vocational Rehabilitation Services." The provisions of these rules establish procedures ~~and~~, requirements, and implement program changes necessitated by the Rehabilitation Act of 1973, as amended, which address the provisions of vocational rehabilitation services to the blind and visually impaired population of Idaho. ~~(1-5-87)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

004. INCORPORATION BY REFERENCE.
The following federal laws and regulations are incorporated by reference into the rules of this chapter and copies are available at the Commission's office: (4-2-08)

01. 29 U.S.C. Section 701, et seq., Rehabilitation Act of 1973 as ~~A~~amended ~~in 1998~~ through Public Law 114-95, enacted December 10, 2015. ~~(4-2-08)~~( )

02. 34 CFR 361 and 363. (4-2-08)

03. Workforce Innovation and Opportunity Act (WIOA), Public Law 113-128, enacted July 22, 2014. ( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.

01. Blind or Visually Impaired. A person whose visual acuity with correcting lenses is not better than twenty/two hundred (20/200) in the better eye; or a person whose vision in the better eye is restricted to a field which subtends an angle of not greater than twenty (20) degrees; or a person who is functionally blind; or a person who is without any sight. (4-2-08)

02. Client. An individual who has applied for, or is determined to be eligible for, vocational rehabilitation services. (4-2-08)

03. Commission. The Idaho Commission for the Blind and Visually Impaired. (4-2-08)

04. Comprehensive Assessment. An assessment of the personality, interests, interpersonal skills, intelligence and related functional capacities, educational achievements, work experience, vocational aptitudes, personal and social adjustments, and employment opportunities of the individual and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational, and environmental factors

that affect the employment and rehabilitation needs of the individual. An assessment also includes, to the degree needed, an appraisal of the patterns of work behavior of the individual and services needed for the individual to acquire occupational skills and to develop work attitudes, work habits, work tolerance, and social and behavior patterns necessary for successful job performance, including the use of work in real job situations to assess and develop the capabilities of the individual to perform adequately in a work environment. (4-2-08)

05. Comparable Benefits or Services. Any benefit or service that exists under any other programs that is available to the client. Examples are, but not limited to, Pell Grants, Medicaid, Medicare, private health insurance, and medical indigence programs for medication. (4-2-08)

06. Designated State Unit. Idaho Commission for the Blind and Visually Impaired. (4-2-08)

07. Functionally Blind. A person with a visual impairment which constitutes or results in a substantial impediment to employment or substantially limits one (1) or more major life activities. This is determined by the vocational rehabilitation counselor, not a physician. (4-2-08)

08. Maintenance. Monetary support provided to an individual for expenses, such as food, shelter, and clothing, that are in excess of the normal expenses of the individual and that are necessitated by the client's participation in an assessment for determining eligibility and vocational rehabilitation needs or the client's receipt of vocational rehabilitation services under an individualized plan for employment (34 CFR 361.5(35)). (4-2-08)

09. Most Significant Disability (MSD). Meets the criteria as Significant Disability as found in the Rehabilitation Act of 1973, as amended, and defined in 34 CFR 361.5(c)(29), and is further defined as: Having a severe physical, mental, cognitive, or sensory impairment which seriously limits three (3) or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance or work skills) in terms of an employment outcome, and whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time. ( )

~~09~~**10. Vocational Rehabilitation Service or Services**. Services that reduce the impact of functional limitations on the ability of a client to achieve an employment outcome. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

210. INDIVIDUAL PLAN FOR EMPLOYMENT.

For those clients determined eligible for vocational rehabilitation services, an IPE shall be developed between the client and their vocational rehabilitation counselor within ninety (90) days of eligibility determination, unless an extension is agreed to between the counselor and client, and documented in the case record. An approved IPE or IPE amendment must be signed by the client or the client's representative and appropriate Commission staff in order to be implemented. Services may be discontinued if the client fails to participate actively or does not make adequate progress toward plan completion. Prior to the IPE being written, a comprehensive assessment is required to evaluate the following components: ~~(4-2-08)~~( )

01. Employment Outcome. To determine the employment outcome that is selected by the client, with input from the vocational rehabilitation counselor, that is consistent with the client's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice. (4-2-08)

a. Provisions of Community Rehabilitation Program Services. The Commission will purchase vocational rehabilitation services from community rehabilitation programs that are accredited by either the Commission on Accreditation of Rehabilitation Facilities (CARF), the Rehabilitation Accreditation Commission, or Rehabilitation Services Accreditation System. In conjunction with the client, the vocational rehabilitation counselor will determine which, if any, community rehabilitation program services are required for the client to achieve an employment outcome. (4-2-08)

02. Nature and Scope. To identify the nature and scope of the vocational rehabilitation services that the client needs to become employed. (4-2-08)

03. Planned Services. To determine how the planned services will assist the client in overcoming the barriers to employment that were identified in the eligibility determination. (4-2-08)

04. Costs. The client must apply for and secure any Comparable Benefits or Services, participate in paying for any or all costs of the IPE services, and make a commitment to cooperate and follow through with the IPE and achieve an employment outcome. Clients receiving services wherein costs are incurred and who possess the financial resources to do so will be required to participate in the payment for assistance provided them. (4-2-08)

211. -- 299. (RESERVED)

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. (3-25-16)

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 t*~~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. ~~*(3-25-16)*~~( )

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. (3-25-16)

b. Education expenses - private in-state institutions. (3-25-16)

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 t*~~Two (2) semesters per federal fiscal year up to an amount not to exceed actual costs per federal fiscal year at a public Idaho 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. ~~*(3-25-16)*~~( )

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. (3-25-16)

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 t*~~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 a public Idaho college ~~*or*~~, university, or other in-state education or training program. 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. ~~*(3-25-16)*~~( )

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 or training program 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 or training program 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. (3-25-16)

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

i. Specialist exam by M.D.: To be paid at specialist's rate not to exceed three hundred dollars ($300) maximum, plus actual cost of related procedures (e.g., x-rays). (3-25-16)

ii. Psychological exam by licensed psychologist: Two hundred fifty dollars ($250) plus actual cost of psychometric tests. (3-25-16)

iii. Ophthalmologist/Optometrist exam: Three hundred dollars ($300) plus actual cost of visual field exam or other necessary tests. (3-25-16)

(1) Low vision exam: To be paid at specialist's rate not to exceed two hundred dollars ($200). (3-25-16)

(2) Follow-up low vision consultation: ~~*Sixty-five*~~ Not to exceed one hundred dollars ($~~*65*~~100). ~~(3-25-16)~~( )

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

iv. Eye glasses or contact lenses: Two hundred dollars ($200) frame costs and the usual and customary cost for lenses and contact lenses. Twelve hundred dollars ($1,200) for bioptics. (3-25-16)

v. Audiologist exam: To be paid at specialists rate not to exceed two hundred dollars ($200). (3-25-16)

vi. Physical exam (general basic medical): Two hundred dollars ($200) plus actual cost of additional procedures and tests. (3-25-16)

f. Psychotherapy/Counseling sessions: Up to one hundred dollars ($100) per hour and up to ten (10) sessions. Exceptions may be made by Rehabilitation Services Chief. (3-25-16)

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. (3-25-16)

h. Dental work, including but not limited to cleaning, fillings, extractions, crowns, and dentures: One thousand dollars ($1,000) per case. (3-25-16)

i. Transportation. (4-2-08)

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

ii. Transportation 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). Exceptions can be approved by the Rehabilitation Services Chief. (3-25-16)

iii. ICBVI may reimburse for state mileage rate for client transportation services or may reimburse for the actual cost of gasoline. (3-25-16)

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: Twenty dollars ($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. (3-25-16)

l. Tools and equipment: Two thousand dollars ($2,000) per case depending on employment goal. Value of tools and equipment provided to client from existing Commission inventory will count towards the two thousand dollar ($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. (3-25-16)

m. On-the-Job training fees: ~~*Three*~~ Five thousand dollars ($~~3~~5,000). ~~*(4-2-08)*~~( )

n. Computers including hardware and software: Two thousand dollars ($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. (3-25-16)

o. Self-employment plans: Three thousand dollars ($3,000), to include tools and equipment, excluding adaptive technology and computers. (3-25-16)

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)

q. 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: (3-25-16)

i. The cost of the modification and/or repair cannot exceed the current Blue Book fair trade in value of the vehicle; (3-25-16)

ii. The client must maintain insurance on the vehicle for replacement cost; (3-25-16)

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. (3-25-16)

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. (3-25-16)

02. Exclusion of Surgery. 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. (3-25-16)

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. (3-25-16)

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. (3-25-16)

(BREAK IN CONTINUITY OF SECTIONS)

356. ORDER OF SELECTION.

01. Prioritizing Services. In the event that ICBVI lacks the personnel or financial resources to provide the full range of VR services to all eligible individuals, the following Order of Selection (OOS) will be used to prioritize service provisions. Students with disabilities, as defined by 34 CFR 361.5(c)(51), who received pre-employment transition services prior to eligibility determination and assignment to a priority category shall continue to receive such services. All clients who have an Individualized Plan for Employment (IPE) will continue to be served. Priority will be given to eligible individuals as follows: ( )

a. Priority 1. Eligible individuals with the Most Significant Disabilities (MSD). ( )

b. Priority 2. Eligible individuals with Significant Disabilities (SD). ( )

c. Priority 3. All other eligible individuals with Disabilities (D). ( )

02. Inability to Serve. If ICBVI cannot serve all eligible individuals within a priority category, individuals will be released from the statewide waitlist based on priority category and date of application. ( )

03. Exemption. Employed individuals, who are eligible for VR services and require immediate equipment or services to maintain their employment, are exempt from the Order of Selection policy, as authorized in the Rehabilitation Act, as amended by WIOA, 34 CFR 361.36(a)(3)(v). ( )

356~~7~~. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.04 – EMERGENCY MEDICAL SERVICES (EMS) – ACCOUNT III GRANTS

DOCKET NO. 16-0104-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 56-1018B, 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 for Emergency Medical Services (EMS) -- Account III Grants has been adopted as pending. 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 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 101-108**.

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 state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication. Funds that are distributed through this program are dedicated funds provided by Section 56-1018B, Idaho Code.

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

DATED this 16th day of November, 2017.

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 56-1018B, Idaho Code.

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

PUBLIC HEARING SCHEDULE

Thursday, September 21, 2017 - 10:30 am (MDT)

Department of Health & Welfare
Bureau of EMS Preparedness
Boise, ID

TELECONFERENCE CALL-IN

Toll Free: 1-213-929-4212
Participant Code: 897-402-816

WEBINAR

Participate through computer and Internet audio
https://attendee.gotowebinar.com/register/3687293052322401 29
PRE-REGISTRATION is required

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

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

The Department is proposing this new chapter of rules in IDAPA 16.01.04, "Emergency Medical Services (EMS) - Account III Grants," to update the processes for EMS grant applications and other requirements for the approval of these grants. The current chapter of rules under IDAPA 16.02.04, "Rules Governing Emergency Medical Services Account III Grants," is being repealed in its entirety in this same Bulletin under Docket No. 16-0204-1701.

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 state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication. Funds that are distributed through this program are dedicated funds provided under Section 56-1018B, Idaho Code.

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 the current chapter Docket No. 16-0204-1701 in the May 3, 2017, Idaho Administrative Bulletin, **Vol. 17-5, pages 63-64**, and the June 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, page 35**.

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 John Cramer 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 September 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0104-1701

IDAPA 16
TITLE 01
CHAPTER 04

16.01.04 – EMERGENCY MEDICAL SERVICES (EMS) – ACCOUNT III GRANTS

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. The Bureau of Emergency Medical Services of the Department of Health and Welfare is responsible under Section 56-1018B, Idaho Code, to administer the Emergency Medical Services Fund III. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.01.04, "Emergency Medical Services (EMS) – Account III Grants." ( )

02. Scope. These rules specify the eligibility criteria, application process, and distribution methodology used by the Department to award grants from this dedicated fund known as the Emergency Medical Services Account III. ( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for 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.
There are no documents incorporated by reference in this chapter of rules. ( )

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, ID 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, ID 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. ( )

c. The FAX number for the Bureau of Emergency Medical Services and Preparedness is (208) 334-4015. ( )

05. Internet Websites. ( )

a. The Department 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. ( )

06. Email Address. The email address for grants is: emsgrants@dhw.idaho.gov. ( )

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

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department's business is subject to the restrictions in state or federal law and 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. -- 009. (RESERVED)

010. DEFINITIONS.
For the purposes of these rules the following definitions apply. ( )

01. Award. The placement of a grant applicant on a prioritized list indicating the potential for receipt of grant approval during the current fiscal year. ( )

02. 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. ( )

03. Capital Equipment. Capital equipment refers to durable goods acquired by an entity but not consumed in the normal course of business. ( )

04. EMS Account III. A dedicated fund subject to appropriation by the Legislature that is established and defined in Section 56-1018B, Idaho Code. ( )

05. 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. ( )

06. EMS Bureau. The Bureau of Emergency Medical Services and Preparedness of the Idaho Department of Health and Welfare. ( )

07. Grant. The disbursement of funds from, or capital equipment purchased by, EMS Account III revenue. ( )

08. Grant Applicant. An entity submitting documents required by the EMS Bureau for the purposes of acquiring funds or capital equipment from the EMS Account III established by Section 56-1018B, Idaho Code. ( )

09. Grant Approval. The disbursement of a grant from EMS Account III to a grant applicant. ( )

10. Grant Cycle. The process of grant application distribution, application submission, awards and approval which occur in accordance with dates established in these rules. ( )

011. -- 099. (RESERVED)

100. AWARD ELIGIBILITY REQUIREMENTS.
To be considered for an award, a grant applicant must be recognized by the EMS Bureau as one (1) of the following: ( )

01. A Currently Licensed EMS Agency. The grant applicant must hold a current Ambulance or Non-Transport License in accordance with IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ( )

02. A Grant Applicant with a Pending Idaho EMS License. Grant approval will not be issued to a grant applicant until an Idaho EMS license has been issued. ( )

a. Grant applicants with a pending Idaho EMS license are ineligible if licensure is not achieved by the grant cycle application deadline described in Section 200 of these rules. ( )

b. Grant applicants determined to be ineligible for an award due to licensure status may reapply in a subsequent grant cycle. ( )

03. A Currently Licensed EMS Agency with a Pending Licensure Change Request. A grant applicant that is a currently licensed EMS agency with a pending change to licensure may receive grant approval for any ambulance or equipment which is necessary for the pending licensure change only if the licensure change is approved by the EMS Bureau. ( )

101. -- 199. (RESERVED)

200. GRANT CYCLE.
The following subsections in this rule provide the grant cycle and due dates the EMS Bureau uses to conduct the grant process. ( )

01. Application Availability. The EMS Bureau provides an application and guidance document available no later than January 1 of each year, which initiates the grant cycle. The application may be accessed online or requested as provided in Section 005 of these rules. ( )

02. Application Period. The grant applicant has through April 1 of the grant cycle to complete and submit the application to the EMS Bureau. The application must be submitted by one (1) of the following methods on or before the due date of the grant cycle: ( )

a. Email is the preferred method and must be received by the end of the due day; ( )

b. Mail must be post marked by the due day; ( )

c. Fax must be received by the end of the due day; or ( )

d. In person, by the close of business on the due day. ( )

03. Application Evaluation Period. The EMS Bureau and state EMS Advisory Committee evaluates the applications received from eligible grant applicants prior to June 1 of the grant cycle. ( )

04. Award Notification. The EMS Bureau issues a notification to every grant applicant regarding the disposition of their grant request prior to July 1 of the grant cycle. ( )

05. Grant Approval. Grant disbursements to the grant applicant occur prior to September 1 of the grant cycle. ( )

06. Return of Unused Grant Funds. All unused grant funds must be returned to the EMS Account III by the grant applicant no later than June l of the next calendar year that ends the grant cycle. ( )

201. APPLICATION REQUIRED.
A completed EMS Bureau grant application must be submitted by the grant applicant on or before the conclusion of the application period specified in Section 200 of these rules. ( )

01. Required Information. The grant applicant must provide the following information for the application: ( )

a. Documentation of one (1) or more vendor price quotes for all capital equipment purchases: ( )

i. Contact EMS Bureau for an Agency Vehicle Fleet Report, to update and return with application; ( )

ii. If requesting a vehicle, updated fleet information must be submitted on a form provided by the Bureau; ( )

iii. If replacing a vehicle, include a copy of the title or registration for the vehicle being replaced; or ( )

iv. If requesting extrication equipment, a list of all personnel trained for extrication operations must be included. ( )

b. Operating budget; ( )

c. All funding sources and revenue generated by source; ( )

d. Contact person for verification of fiscal information; ( )

e. Federal Tax Identification Number; ( )

f. Resident population within the grant applicant's response area in Idaho; ( )

g. Type, and quantity of EMS Responses and run dispositions occurring during the specified time-period accompanied by supporting documents generated by the agency dispatch computer system or the agency electronic patient care reporting system; ( )

h. Type, quantity, and purpose of similar equipment presently in use by the applicant; ( )

i. Age and condition of equipment being replaced if applicable; ( )

j. Narrative descriptions of need; ( )

k. Prioritization by the grant applicant of equipment requested when the application requests funding for two (2) or more items or groups of identical items; and ( )

l. City or County governmental endorsement. ( )

02. Incomplete Application. A grant application that is missing required information is excluded from consideration for an award. ( )

03. Application Purpose. The grant application and any attachments submitted by the grant applicant are the primary source of information for awarding a grant. ( )

202. -- 299. (RESERVED)

300. AWARD RECOMMENDATION.
IDAPA 16.01.01, "Emergency Medical Services (EMS) -- Advisory Committee (EMSAC)," Section 120, provides that EMSAC is responsible for reviewing and making recommendations to the EMS Bureau regarding the distribution of grant funds. ( )

01. Assessment and Validation of Need. The EMSAC must review grant applications prior to EMSAC making a recommendation to the EMS Bureau regarding the distribution of awards. ( )

02. Contingency Awards. The EMSAC may make recommendations regarding what awards the EMS Bureau may consider in the event that an award grant application is withdrawn as described in Section 501 of these rules. ( )

301. CRITERIA FOR EMS VEHICLES.
The following criteria must be used to evaluate applications for EMS vehicles, with maximum weight available for each criterion as indicated. Greater weight will be assigned to those conditions which indicate greater need for each criterion: ( )

01. Applicant Fleet Size. The number and type of vehicles currently in use by the grant applicant; weight = ten (10). The application demonstrating a smaller fleet size will be assigned greater weight. ( )

02. Age of Applicant Vehicle(s). The number of years which has elapsed since the vehicle being replaced was originally manufactured or rechassied; weight = fifteen (15). The application demonstrating greater age of vehicle(s) will be assigned greater weight. ( )

03. Mileage of Applicant Vehicle(s). The number of miles reflected on the vehicle odometer at the time of application; weight = fifteen (15). The application demonstrating higher mileage of similar vehicles in active use will be assigned greater weight. ( )

04. Deployment Ratios. A mathematical comparison of current and post-grant vehicle availability based on the number of similar vehicles divided by the applicant coverage area in square miles and the number of similar vehicles divided by the population; weight = fifteen (15). The application demonstrating a greater change in deployment ratio will be assigned greater weight. ( )

05. EMS Response Type. A comparison of pre-hospital EMS Response Types and total EMS Responses; weight = ten (10). The application demonstrating a higher percent of pre-hospital calls will be assigned a greater weight. ( )

06. Fiscal Resource Base. The proportion of operating budget supported by public funds; weight = ten (10). The application demonstrating less revenue from public funds expressed as a percent of total revenue for the most recent year will be assigned greater weight. ( )

07. Local Government Endorsement. Local government endorsements from Idaho cities and counties within the applicant's primary response area; weight = five (5). Applications submitted with one (1) or more endorsement(s) will be awarded five (5) points. ( )

08. Prevalence of Volunteers. The percent of certified personnel identified on the most recent agency license application as volunteer; weight = percent/10. The application demonstrating a greater prevalence of volunteer certified personnel will be assigned greater weight. ( )

09. Narrative. The need for and lack of availability of funds from other sources as documented by the grant applicant; weight = ten (10). The application demonstrating a greater need for and lack of available funds will be assigned greater weight. ( )

10. Previous Award of Vehicle by EMS Account III Grant. Based on most recent vehicle award applicants will receive points based on elapsed time from most recent vehicle award; weight = five (5). The application declaring a recent vehicle award will be assigned a lesser value. ( )

302. CRITERIA FOR OTHER EMS EQUIPMENT.
The following criteria must be used to evaluate grant applications for other EMS equipment, with maximum weight available for each criterion as indicated. Greater weight will be assigned to those conditions which indicate greater need for each criterion: ( )

01. Applicant Equipment. The number, type and age of similar equipment currently in use by the grant applicant; weight = fifteen (15). The application demonstrating lack of accessibility to similar equipment will be assigned greater weight. ( )

02. Anticipated Use. An estimate of the frequency and patient types for which the equipment may be used based on utilization percentages for the specified period; weight = fifteen (15). The application demonstrating greater anticipated use will be assigned greater weight. ( )

03. Duration of Use. An estimate of the length of time the equipment would be used for a patient when indicated, expressed as a mean time; weight = fifteen (15). The application demonstrating a greater duration of use will be assigned greater weight. ( )

04. Deployment Ratios. A mathematical comparison of current and post-grant equipment availability based on number of pieces of similar equipment divided by the applicant coverage area in square miles and the number of pieces of similar equipment divided by population; weight = fifteen (15). The application demonstrating a greater change in deployment ratio will be assigned greater weight. ( )

05. EMS Response Type. A comparison of pre-hospital EMS Response Types and total EMS Responses; weight = ten (10). The application demonstrating a higher percent of pre-hospital calls will be assigned a greater weight. ( )

06. Fiscal Resource Base. The proportion of operating budget supported by public funds; weight = ten (10). The application demonstrating less revenue from public funds expressed as a percent of total revenue for the

most recent year will be assigned greater weight. ( )

07. Local Government Endorsement. Local government endorsements from Idaho cities and counties within the applicant's primary response area; weight = five (5). Applications submitted with one (1) or more endorsement(s) will be awarded five (5) points. ( )

08. Prevalence of Volunteers. The percent of certified personnel identified on the most recent agency license application as volunteer; weight = percent/10. The application demonstrating a greater prevalence of volunteer certified personnel will be assigned greater weight. ( )

09. Narrative. The need for and lack of availability of funds from other sources as documented by the grant applicant; weight = ten (10). The application demonstrating a greater need for and lack of available funds will be assigned greater weight. ( )

303. -- 399. (RESERVED)

400. SECURITY INTEREST.
Each successful grant applicant is required to execute a security agreement as required in Section 56-1018B(2)(e), Idaho Code. The security agreement must be a signed by the person authorizing the grant application. The Department provides a Subgrant and Security Agreement for Vehicle/Equipment for signature. ( )

401. -- 499. (RESERVED)

500. UNUSED GRANT FUNDS.
All funds not expended for costs associated with the applicant's award must be returned to the EMS Account III by June 1 of the grant cycle during which the funds were awarded. ( )

501. WITHDRAWAL OF GRANT APPLICATION.
Any grant applicant may withdraw or forfeit a grant application at any time. ( )

01. Notification. The EMS Bureau may discontinue the grant award or approval process if either of the following occurs: ( )

a. The chief administrative official of the grant applicant agency or his designee submits a notice of withdrawal in written form to the EMS Bureau; or ( )

b. The grant applicant does not provide required documentation during the award or approval process. ( )

02. No Right of Assignment. The grant applicant may not assign any award. ( )

03. Ability to Compete. The withdrawal of a grant application does not affect the grant applicant's ability to reapply in a subsequent grant cycle. ( )

502. FRAUDULENT INFORMATION ON GRANT APPLICATION.
Providing false information on any grant application or document submitted under these rules is grounds for declaring the grant applicant ineligible. Any and all funds determined to have been acquired on the basis of fraudulent information must be returned to the EMS III account. ( )

503. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.02 – RULES OF THE IDAHO EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 56-1013A 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 has revised 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.

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 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 229 and 230**.

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 16th day of November, 2017.

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 18, 2017.

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.

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 throughout the year and at the quarterly meetings of the EMS Physician Commission.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2018-1, 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. Once the docket has been finalized and adopted, the manual will be available online at: **www.emspc.dhw.idaho.gov**.

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 25, 2017.

DATED this 1st day of September, 2017.

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0202-1701

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~~7~~8-1, 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. ~~(7-1-17)~~( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.04 – RULES GOVERNING EMERGENCY MEDICAL SERVICES ACCOUNT III GRANTS

DOCKET NO. 16-0204-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 56-1018B, Idaho Code.

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

This chapter of rules for Emergency Medical Services Account III Grants is being repealed and has been adopted as pending. 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 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 109-110**.

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 state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication. Funds that are distributed through this program are dedicated funds provided by Section 56-1018B, Idaho Code.

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

DATED this 16th day of November, 2017.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
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Phone: (208) 334-5500
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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 56-1018B, Idaho Code.

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

PUBLIC HEARING

Thursday, September 21, 2017 - 10:30 am (MDT)

Department of Health & Welfare
Bureau of EMS Preparedness
Boise, ID

TELECONFERENCE CALL-IN

Toll Free: 1-213-929-4212
Participant Code: 897-402-816

WEBINAR

Participate through computer and Internet audio
https://attendee.gotowebinar.com/register/3687293052322401 29
PRE-REGISTRATION is required

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

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

This chapter of rules in IDAPA 16.02.04, "Rules Governing Emergency Medical Services Account III Grants," is being repealed in its entirety. The Department is promulgating a new chapter of rules in this same Bulletin under IDAPA 16.01.04, "Emergency Medical Services (EMS) - Account III Grants," Docket No. 16-0104-1701.

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 state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication. Funds that are distributed through this program are dedicated funds provided by Section 56-1018B, Idaho Code.

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 3, 2017, Idaho Administrative Bulletin, **Vol. 17-5, pages 63-64**, and the June 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, page 35**.

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 John Cramer 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 September 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

IDAPA 16.02.04 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.10 – IDAHO REPORTABLE DISEASES

DOCKET NO. 16-0210-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 39-605, 39-1603, 56-1003, and 56-1005, 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 Arboviral Diseases were added to the list of Diseases and Control Measures that are required to be reported, and includes how the diseases are to be investigated, and any restrictions necessary for facilities or individuals. The summary table for Reportable and Restrictable Diseases and Conditions was updated for necessary references and language as needed. Also, language that was inadvertently added in a previous rulemaking in the wrong subsection was removed. Documents incorporated by reference were updated, and pertinent portions of the Rabies - Human, Animal, and Post-Exposure Prophylaxis (rPEP) section (Section 610) were updated to align with the newly incorporated references.

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 January 4, 2017, Idaho Administrative Bulletin, **Vol. 17-1, pages 96 through109**.

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 state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Kathryn Turner at (208) 334-5939.

DATED this 16th day of November, 2017.

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 PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2017.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-605, 39-1603, 56-1003, and 56-1005, 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 January 18, 2017.

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 Arboviral Diseases are being added to the list of Diseases and Control Measures that are required to be reported, and includes how the diseases are to be investigated, and any restrictions necessary for facilities or individuals. The summary table for Reportable and Restrictable Diseases and Conditions will be updated for necessary references and language as needed. Also, language that was inadvertently added in a previous rulemaking in the wrong subsection will be removed. Documents that have been incorporated by reference are being updated as noted below.

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

In order to protect the public health, safety, or welfare, these rules need to add the requirement to report Arboviral Diseases, including the emerging Zika virus, to the list of Idaho Reportable Diseases.

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

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

There is no anticipated fiscal impact to state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the Department determined it was not feasible since the rule is a temporary rule and is needed to protect the public health, safety, and welfare.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following documents are being incorporated by reference in this chapter of rules to give them the force and effect of law. The documents are not being reprinted due to the length, format, and/or the cost for republication.

Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, is being updated from Morbidity and Mortality Weekly Report, September 2005, to the Infection Control and Hospital Epidemiology, September 2013.

Compendium of Animal Rabies Control is being updated from the Morbidity and Mortality Weekly Report, November 2011, to the Journal of American Veterinary Medical Association, March 2016.

Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices, 2010, is being incorporated by reference.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Kathryn Turner at (208) 334-5939.

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 January 25, 2017.

DATED this 17th day of November, 2016.

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis

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. 16-0210-1701

004. DOCUMENTS INCORPORATED BY REFERENCE.
The documents referenced in Subsections 004.01 through 004.0~~6~~7 of this rule are used as a means of further clarifying these rules. These documents are incorporated by reference and are available at the Idaho State Law Library or at the Department's main office listed in Section 005 of these rules. ~~(4-2-08)~~( )

01. Guideline for Isolation Precautions in Hospitals. Siegel, J.D., et al., "Guideline for Isolation Precautions in Hospitals." Health Care Infection Control Practices Advisory Committee, Atlanta, GA: Centers for Disease Control and Prevention, 2007. (4-2-08)

02. National Notifiable Diseases Surveillance System - Case Definitions. http://wwwn.cdc.gov/nndss/script/casedefDefault.aspx. (4-11-15)

~~***a.*** *A person, who has been diagnosed as having a specific disease or condition by a physician or other health care provider, is considered a case. The diagnosis may be based on clinical judgment, on laboratory evidence, or on both criteria. Individual case definitions are described in "National Notifiable Diseases Surveillance System Case Definitions," incorporated by reference in Section 004 of these rules.* *(4-11-15)*~~

~~***b.*** *A laboratory detection of a disease or condition as listed in Section 050 of these rules and as further outlined in Sections 100 through 949 of these rules.* *(4-11-15)*~~

03. Human Rabies Prevention -- United States, 2008. Morbidity and Mortality Weekly Report, May 23, 2008, Vol. 57.RR-3. Centers for Disease Control and Prevention. (4-11-15)

04. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. ~~*Morbidity and Mortality Weekly Report*~~ Infection Control and Hospital Epidemiology, September ~~*30,*~~ 20~~05~~13, Vol. ~~5~~34, ~~*RR0*~~9.

~~Centers for Disease Control and Prevention~~ The Society for Healthcare Epidemiology of America. These guidelines are found online at ~~http://aidsinfo.nih.gov/contentfiles/HealthCareOccupExpoGL.pdf~~ http://www.jstor.org/stable/10.1086/672271. ~~(3-29-10)~~( )

05. Compendium of Animal Rabies Prevention and Control, 201~~4~~6. National Association of State Public Health Veterinarians, Inc., ~~Morbidity and Mortality Weekly Report, November 4, 2011, Vol. 60.RR-6. Centers for Disease Control and Prevention~~ Journal of American Veterinary Medical Association Vol. 248(5), March 1, 2016. This document is found online at ~~http://www.nasphv.org/Documents/RabiesCompendium.pdf~~ http://nasphv.org/documentsCompendia.html. ~~(4-11-15)~~( )

06. Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary. North American Association of Central Cancer Registries, Eighteenth Edition, Record Layout Version 14, September 2013. (4-11-15)

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

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS A THROUGH K.
For the purposes of this chapter, the following definitions apply. (4-2-08)

01. Airborne Precautions. Methods used to prevent airborne transmission of infectious agents, as described in "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. (4-2-08)

02. Approved Fecal Specimens. Specimens of feces obtained from the designated person who has not taken any antibiotic orally or parenterally for two (2) days prior to the collection of the fecal specimen. The specimen must be collected and transported to the laboratory in a manner appropriate for the test to be performed. (4-2-08)

03. Bite or Other Exposure to Rabies. Bite or bitten means that the skin of the person or animal has been nipped or gripped, or has been wounded or pierced, including scratches, and includes probable contact of saliva with a break or abrasion of the skin. The term "exposure" also includes contact of saliva with any mucous membrane. In the case of bats, even in the absence of an apparent bite, scratch, or mucous membrane contact, exposure may have occurred, as described in "Human Rabies Prevention -- United States, ~~2008,~~" incorporated in Section 004 of these rules. ~~(4-11-15)~~( )

04. Board. The Idaho State Board of Health and Welfare as described in Section 56-1005, Idaho Code. (4-2-08)

05. Cancer Data Registry of Idaho (CDRI). The agency performing cancer registry services under a contractual agreement with the Department as described in Section 57-1703, Idaho Code. (4-2-08)

06. Cancers. Cancers that are designated reportable include the following as described in Section 57-1703, Idaho Code: (4-2-08)

a. In-situ or malignant neoplasms, but excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix. (4-2-08)

b. Benign tumors of the brain, meninges, pineal gland, or pituitary gland. (4-2-08)

07. Carrier. A carrier is a person who can transmit a communicable disease to another person, but may not have symptoms of the disease. (4-2-08)

08. Case. (4-2-08)

a. A person, who has been diagnosed as having a specific disease or condition by a physician or other health care provider, is considered a case. The diagnosis may be based on clinical judgment, on laboratory evidence, or on both criteria. Individual case definitions are described in "National Notifiable Diseases Surveillance System Case Definitions," incorporated in Section 004 of these rules. (4-11-15)

b. A laboratory detection of a disease or condition as listed in Section 050 of these rules and as further outlined in Sections 100 through 949 of these rules. (4-2-08)

09. Cohort System. A communicable disease control mechanism in which cases having the same disease are temporarily segregated to continue to allow supervision and structured attendance in a daycare or health care facility. (4-2-08)

10. Communicable Disease. A disease which may be transmitted from one (1) person or an animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means which may result in infection, illness, disability, or death. (4-2-08)

11. Contact. A contact is a person who has been exposed to a case or a carrier of a communicable disease while the disease was communicable, or a person by whom a case or carrier of a communicable disease could have been exposed to the disease. (4-11-15)

12. Contact Precautions. Methods used to prevent contact transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. (4-2-08)

13. Daycare. Care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood or marriage to the person or persons providing the care, in a place other than the child's or children's own home or homes as described by Section 39-1102, Idaho Code. (4-2-08)

14. Department. The Idaho Department of Health and Welfare or its designee. (4-2-08)

15. Director. The Director of the Idaho Department of Health and Welfare or his designee as described under Sections 56-1003 and 39-414(2), Idaho Code, and Section 950 of these rules. (4-2-08)

16. Division of Public Health Administrator. A person appointed by the Director to oversee the administration of the Division of Public Health, Idaho Department of Health and Welfare, or his designee. (4-2-08)

17. Droplet Precautions. Methods used to prevent droplet transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. (4-2-08)

18. Exclusion. An exclusion for a food service facility means a person is prevented from working as a food employee or entering a food establishment except for those areas open to the general public as outlined in the IDAPA 16.02.19, "The Idaho Food Code." (4-2-08)

19. Extraordinary Occurrence of Illness Including Clusters. Rare diseases and unusual outbreaks of illness which may be a risk to the public are considered an extraordinary occurrence of illness. Illnesses related to drugs, foods, contaminated medical devices, contaminated medical products, illnesses related to environmental contamination by infectious or toxic agents, unusual syndromes, or illnesses associated with occupational exposure to physical or chemical agents may be included in this definition. (4-2-08)

20. Fecal Incontinence. A condition in which temporarily, as with severe diarrhea, or long-term, as with a child or adult requiring diapers, there is an inability to hold feces in the rectum, resulting in involuntary voiding of stool. (4-2-08)

21. Foodborne Disease Outbreak. An outbreak is when two (2) or more persons experience a similar

illness after ingesting a common food. (4-2-08)

22. Food Employee. An individual working with unpackaged food, food equipment or utensils, or food-contact surfaces as defined in IDAPA 16.02.19, "The Idaho Food Code." (4-2-08)

23. Health Care Facility. An establishment organized and operated to provide health care to three (3) or more individuals who are not members of the immediate family. This definition includes hospitals, intermediate care facilities, residential care and assisted living facilities. (4-2-08)

24. Health Care Provider. A person who has direct or supervisory responsibility for the delivery of health care or medical services. This includes: licensed physicians, nurse practitioners, physician assistants, nurses, dentists, chiropractors, and administrators, superintendents, and managers of clinics, hospitals, and licensed laboratories. (4-2-08)

25. Health District. Any one (1) of the seven (7) public health districts as established by Section 39-409, Idaho Code, and described in Section 030 of these rules. (4-2-08)

26. Health District Director. Any one (1) of the public health districts' directors appointed by the Health District's Board as described in Section 39-413, Idaho Code, or his designee. (4-2-08)

27. Idaho Food Code. Idaho Administrative Code that governs food safety, IDAPA 16.02.19, "Food Safety and Sanitation Standards for Food Establishments," also known as "The Idaho Food Code." These rules may be found online at http://adminrules.idaho.gov/rules/current/16/0219.pdf. (4-2-08)

28. Isolation. The separation of a person known or suspected to be infected with an infectious agent, or contaminated from chemical or biological agents, from other persons to such places, under such conditions, and for such time as will prevent transmission of the infectious agent or further contamination. The place of isolation will be designated by the Director under Section 56-1003(7), Idaho Code, and Section 065 of these rules. (4-2-08)

011. DEFINITIONS L THROUGH Z.
For the purposes of this chapter, the following definitions apply. (4-2-08)

01. Laboratory Director. A person who is directly responsible for the operation of a licensed laboratory or his designee. (4-2-08)

02. Laboratory. A medical diagnostic laboratory which is inspected, licensed, or approved by the Department or licensed according to the provisions of the Clinical Laboratory Improvement Act by the United States Health Care and Financing Administration. Laboratory may also refer to the Idaho State Public Health Laboratory, and to the United States Centers for Disease Control and Prevention. (4-2-08)

03. Livestock. Livestock as defined by the Idaho Department of Agriculture in IDAPA 02.04.03, "Rules Governing Animal Industry." (4-11-15)

04. Medical Record. Hospital or medical records are all those records compiled for the purpose of recording a medical history, diagnostic studies, laboratory tests, treatments, or rehabilitation. Access will be limited to those parts of the record which will provide a diagnosis, or will assist in identifying contacts to a reportable disease or condition. Records specifically exempted by statute are not reviewable. (4-2-08)

05. Outbreak. An outbreak is an unusual rise in the incidence of a disease. An outbreak may consist of a single case. (4-2-08)

06. Personal Care. The service provided by one (1) person to another for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding, and other services involving direct physical contact. (4-2-08)

07. Physician. A person legally authorized to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho as defined in Section 54-1803, Idaho Code. (4-2-08)

08. Quarantine. The restriction placed on the entrance to and exit from the place or premises where an infectious agent or hazardous material exists. The place of quarantine will be designated by the Director or Health District Board. (4-2-08)

09. Rabies Post-Exposure Prophylaxis (rPEP). The administration of a rabies vaccine series with or without the antirabies immune globulin, depending on pre-exposure vaccination status, following a documented or suspected rabies exposure, as described in "~~*Human Rabies Prevention - United States, 2008,*~~ Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices," incorporated in Section 004 of these rules. ~~*(4-11-15)*~~( )

10. Rabies-Susceptible Animal. Any animal capable of being infected with the rabies virus. (4-2-08)

11. Residential Care Facility. A commercial or non-profit establishment organized and operated to provide a place of residence for three (3) or more individuals who are not members of the same family, but live within the same household. Any restriction for this type of facility is included under restrictions for a health care facility. (4-2-08)

12. Restriction. (4-2-08)

a. To limit the activities of a person to reduce the risk of transmitting a communicable disease. Activities of individuals are restricted or limited to reduce the risk of disease transmission until such time that they are no longer considered a health risk to others. (4-2-08)

b. A food employee who is restricted must not work with exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles. A restricted employee may still work at a food establishment as outlined in the IDAPA 16.02.19, "The Idaho Food Code." (4-2-08)

13. Restrictable Disease. A restrictable disease is a communicable disease, which if left unrestricted, may have serious consequences to the public's health. The determination of whether a disease is restrictable is based upon the specific environmental setting and the likelihood of transmission to susceptible persons. (4-2-08)

14. Severe Reaction to Any Immunization. Any serious or life-threatening condition which results directly from the administration of any immunization against a communicable disease. (4-2-08)

15. Significant Exposure to Blood or Body Fluids. Significant exposure is defined as a percutaneous injury, contact of mucous membrane or non-intact skin, or contact with intact skin when the duration of contact is prolonged or involves an extensive area, with blood, tissue, or other body fluids as defined in "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis," incorporated in Section 004 of these rules. (3-29-10)

16. Standard Precautions. Methods used to prevent transmission of all infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. (4-2-08)

17. State Epidemiologist. A person employed by the Department to serve as a statewide epidemiologist or his designee. (4-2-08)

18. Suspected Case. A person diagnosed with or thought to have a particular disease or condition by a licensed physician or other health care provider. The suspected diagnosis may be based on signs and symptoms, or on laboratory evidence, or both criteria. Suspected cases of some diseases are reportable as described in Section 050 of these rules. (4-2-08)

19. Vaccination of an Animal Against Rabies. Vaccination of an animal by a licensed veterinarian with a rabies vaccine licensed or approved for the animal species and administered according to the specifications on the product label or package insert as described in the "Compendium of Animal Rabies Prevention and Control, ~~*2011,*~~" incorporated in Section 004 of these rules. ~~*(4-11-15)*~~( )

20. **Veterinarian**. Any licensed veterinarian as defined in Section 54-2103, Idaho Code. (4-2-08)

21. **Waterborne Outbreak**. An outbreak is when two (2) or more persons experience a similar illness after exposure to water from a common source and an epidemiological analysis implicates the water as the source of the illness. (4-11-15)

22. **Working Day**. A working day is from 8 a.m. to 5 p.m., Monday through Friday, excluding state holidays. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

050. REPORTABLE OR RESTRICTABLE DISEASES, CONDITIONS AND REPORTING REQUIREMENTS.
Reportable diseases and conditions must be reported to the Department or Health District by those required under Section 020 of these rules. The table below identifies the reportable and restrictable diseases and conditions, the timeframe for reporting, and the person or facility required to report.

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS
TABLE 050

Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Acquired Immune Deficiency Syndrome (AIDS), (including CD-4 lymphocyte counts <200 cells/mm3 blood or < 14%)	100	Within 3 working days	None	
Amebiasis and Free-living Amebae	110	Within 3 working days	DC, FS, HC	Food Service Facility
Anthrax (*Bacillus anthracis*)	120	Immediately	None	
Arboviral Diseases	125	Within 3 working days	None	
Biotinidase Deficiency	130	Within 1 working day (in newborn screening)	None	
Botulism	140	Immediately	None	
Brucellosis (*Brucella* species)	150	Within 1 working day	None	
Campylobacteriosis (*Campylobacter* species)	160	Within 3 working days	DC, FS, HC	Food Service Facility
Cancer	170	Report to Cancer Data Registry of Idaho within 180 days of diagnosis or recurrence (including suspected cases)	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Chancroid	180	Within 3 working days	None	
Chlamydia trachomatis Infections	190	Within 3 working days	HC - ophthalmia neonatorum only	
Cholera (*Vibrio cholerae*)	200	Within 1 working day	FS, HC, DC	Food Service Facility
Congenital Hypothyroidism	210	Within 1 working day (in newborn screening)	None	
Conjunctivitis	080, 090	No reporting required	DC, S	
Cryptosporidiosis (*Cryptosporidium* species)	220	Within 3 working days	FS, HC, DC	
Cutaneous Fungal Infections	080, 090	No reporting required	DC, S	
Diarrhea (until common communicable diseases have been ruled out)	085	No reporting required	FS	
Diphtheria (*Corynebacterium diphtheriae*)	230	Immediately	DC, FS, HC, S	School
Echinococcosis	235	Within 3 working days	None	
Encephalitis, Viral or Aseptic	240	Within 3 working days	None	
Escherichia coli O157:H7 and other Shiga-Toxin Producing *E. coli* (STEC)	250	Within 1 working day	DC, FS, HC	Food Service Facility School
Extraordinary Occurrence of Illness, including Clusters	260	Within 1 working day	None	
Fever	085	No reporting required	FS	
Food Poisoning, Foodborne Illness, and Waterborne Illnesses	270	Within 1 working day	None	
Galactosemia	280	Within 1 working day (in newborn screening)	None	
Giardiasis (*Giardia lamblia*)	290	Within 3 working days	DC, FS, HC	Food Service Facility
Haemophilus influenzae Invasive Disease	300	Within 1 working day	DC, S	School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Hantavirus Pulmonary Syndrome	310	Within 1 working day	None	
Hemolytic-Uremic Syndrome (HUS) or Thrombotic thrombocytopenic purpura-HUS (TTP-HUS)	320	Within 1 working day	None	
Hepatitis A	330	Within 1 working day	DC, FS, HC	Food Service Facility
Hepatitis B	340	Within 1 working day	None	
Hepatitis C	350	Within 3 working days	None	
Human Immunodeficiency Virus (HIV)	360	Within 3 working days	None	
Human T-Lymphotropic Virus	370	Within 3 working days	None	
Jaundice	085	No reporting required	FS	
Lead Poisoning	380	Within 3 working days	None	
Legionellosis	390	Within 3 working days	None	
Leprosy (Hansen's Disease)	400	Within 3 working days	None	
Leptospirosis	410	Within 3 working days	None	
Listeriosis (*Listeria* species)	420	Within 3 working days	None	
Lyme Disease	430	Within 3 working days	None	
Malaria (*Plasmodium* species)	440	Within 3 working days	None	
Maple Syrup Urine Disease	450	Within 1 working day (in newborn screening)	None	
Measles (Rubeola)	460	Within 1 working day	DC, HC, S	School
Meningitis, Viral or Aseptic	470	Within 3 working days	None	
Methicillin-resistant *Staphylococcus aureus* (MRSA) Invasive Disease	475	Within 3 working days	None	**Note:** Only Laboratory Directors need to report.
Methicillin-resistant *Staphylococcus aureus* (MRSA) Non-Invasive Disease	475, 080, 090	No reporting required	DC, FS, HC, S	
Mumps	480	Within 3 working days	DC, S, HC	School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Myocarditis, Viral	490	Within 3 working days	None	
Neisseria gonorrhoeae Infections	500	Within 3 working days	HC-ophthalmia neonatorum only	
Neisseria meningitidis Invasive Disease	510	Within 1 working day	DC, HC, S	School
Norovirus	520	Within 1 working day	DC, FS, HC, S	
Novel Influenza A Virus	522	Within 1 working day	DC, FS, HC, S	
Pediculosis	080, 090	No reporting required	DC, S	
Pertussis (*Bordetella pertussis*)	530	Within 1 working day	DC, HC, S	School
Phenylketonuria (PKU)	540	Within 1 working day (in newborn screening)	None	
Plague (*Yersinia pestis*)	550	Immediately	HC, S	School
Pneumococcal Invasive Disease in Children less than Eighteen (18) Years of Age *(Streptococcus pneumoniae)*	560	Within 3 working days	DC, S	School
Pneumocystis Pneumonia (PCP)	570	Within 3 working days	None	
Poliomyelitis	580	Within 1 working day	DC	School
Psittacosis	590	Within 3 working days	None	
Q Fever	600	Within 1 working day	None	
Rabies - Human, Animal, and Post-Exposure Prophylaxis (rPEP)	610	Immediately (human), Within 1 working day (animal or rPEP)	None	
Relapsing Fever, Tick-borne and Louse-borne	620	Within 3 working days	None	
Respiratory Syncytial Virus (RSV)	630	Within 1 working day	None	**Note:** Only Laboratory Directors need to report.
Reye Syndrome	640	Within 3 working days	None	
Rocky Mountain Spotted Fever	650	Within 3 working days	None	
Rubella (including Congenital Rubella Syndrome)	660	Within 1 working day	DC, HC, S	School

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Salmonellosis (including Typhoid Fever) (*Salmonella* species)	670	Within 1 working day	DC, FS, HC	Food Service Facility
Scabies	080, 090	No reporting required	DC, S	
Severe Acute Respiratory Syndrome (SARS)	680	Within 1 working day	DC, S	School
Severe Reaction to Any Immunization	690	Within 1 working day	None	
Shigellosis (*Shigella* species)	700	Within 1 working day	DC, FS, HC, S	Food Service Facility School
Smallpox	710	Immediately	DC, HC, S	School
Sore Throat with Fever	085	No reporting required	FS	
Staphylococcal Infections other than MRSA	080, 085, 090	No reporting required	DC, FS, S	
Streptococcal Pharyngeal Infections	080, 090	No reporting required	DC, S	
Streptococcus pyogenes (group A strep), Invasive or Resulting in Rheumatic Fever	720	Within 3 working days	DC, HC, S	School
Syphilis	730	Within 3 working days	None	
Taeniasis	085	No reporting required	FS	
Tetanus	740	Within 3 working days	None	
Toxic Shock Syndrome	750	Within 3 working days	None	
Transmissible Spongiform Encephalopathies (TSE), including Creutzfeldt-Jakob Disease (CJD) and Variant CJD (vCJD)	760	Within 3 working days	None	
Trichinosis	770	Within 3 working days	None	
Tuberculosis (*Mycobacterium tuberculosis*)	780	Within 3 working days	DC, FS, HC, S	School Food Service Facility

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Tularemia (*Francisella tularensis*)	790	Immediately; Identification of *Francisella tularensis* - within 1 working day	None	
Uncovered and Open or Draining Skin Lesions with Pus, such as a Boil or Open Wound	085	No reporting required	FS	
Varicella (chickenpox)	080, 090	No reporting required	DC, S	
Vomiting (until noninfectious cause is identified)	085	No reporting required	FS	
~~*West Nile Virus (WNV)*~~	~~*800*~~	~~*Within 3 working days*~~	~~*None*~~	
Yersiniosis (*Yersinia enterocolitica* and *Yersinia pseudotuberculosis*)	810	Within 3 working days; Identification of *Yersinia pestis* - immediately	FS	

~~*(4-11-15)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

121. -- 12~~9~~4. (RESERVED)

125. ARBOVIRAL DISEASES.

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

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

126. -- 129. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

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

01. Reporting Requirements. (4-2-08)

a. Each case or suspected case of rabies in humans must be reported to the Department or Health District immediately, at the time of identification, day or night. (4-2-08)

b. Each case of rabies in animals must be reported to the Department or Health District within one (1) working day of identification. ~~*Each case of rabies in animals must also be reported to the Department of Agriculture as required in IDAPA 02.04.03, "Rules Governing Animal Industries."* (3-29-10)~~( ) (3-29-10)

c. Each instance of rabies post-exposure prophylaxis (rPEP) series initiation must be reported to the Department or Health District within one (1) working day. (4-2-08)

02. Investigation. (4-2-08)

a. Each reported case or suspected case of rabies in humans must be investigated to confirm the diagnosis, identify the source and other persons or animals that may have been exposed to the source, and identify persons who may need to undergo rPEP. (3-29-10)

b. Each suspected or confirmed case of rabies in animals will be investigated to determine if potential human or animal exposure has occurred and identify persons who may need to undergo rPEP. (3-29-10)

c. Each reported rPEP series initiation must be investigated to determine if additional individuals require rPEP and identify the source of possible rabies exposure. (3-29-10)

03. Handling of Report. The Health District must notify the Department within one (1) working day of each reported case of this disease. (4-11-15)

04. Management of Exposure to Rabies. All *human* exposures to a suspected or confirmed rabid animal must be managed *as described* under the guidelines *presented* in the *"Human Rabies Prevention -- United States" incorporated by reference in Subsection 004.03 of these rules and "Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices" incorporated by reference in Subsection 004.07 in these rules. Animals involved with bites, or themselves bitten by a suspected or confirmed rabid animal, must be managed under the guidelines in the* "Compendium of Animal Rabies Prevention and Control, ~~*2011,*~~" incorporated by reference in S*ubs*ection 004.*05* of these rules*, and as described in Subsections 610.04.a., 610.04.b., and 610.04.c. below*. In the event that a human or animal case of rabies occurs, any designated representative of the Department, Health District, or Idaho *State* Department of Agriculture, will establish such isolation and quarantine of animals involved as deemed necessary to protect the public health. ~~*(4-11-15)*~~( ) (4-11-15)

a. The ~~*handling*~~ *management* of a rabies-susceptible animal that has bitten *or otherwise potentially exposed* a person *to rabies* must be as follows: ~~*(4-2-08)*~~( ) (4-2-08)

i. Any livestock ~~*which*~~ *that* has bitten *or otherwise potentially exposed* a person ~~*must be managed*~~ *to rabies will be referred to* ~~*by*~~ the Idaho *State* Department of Agriculture *for management*. ~~*(4-2-08)*~~( ) (4-2-08)

ii. Any healthy domestic dog, cat, or ferret*, regardless of rabies vaccination status,* that has bitten *or otherwise potentially exposed* a person *to rabies* must be *confined and* observed *for illness daily* for ten (10) days following the ~~*bite*~~ *exposure* under the supervision of a licensed veterinarian or other person designated by the Idaho *State* Department of Agriculture, Health District, or the Department. ~~*Such observation must be within an enclosure or with restraints deemed adequate to prevent contact with any member of the public or other animals*~~ *If signs suggestive of rabies develop, immediately consult the Health District or Department to discuss euthanasia and rabies testing*. ~~*(4-2-08)*~~( ) (4-2-08)

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

i~~i~~v. It is the animal owner's responsibility ~~to carry out the quarantine of the biting animal and~~ to follow instructions provided for the ~~quarantine~~ *management* of the animal. ~~(4-2-08)~~*( )*

~~iv. Any domestic dog, cat, or ferret that has not been vaccinated against rabies by a licensed veterinarian and can not be quarantined, must be destroyed by a means other than shooting in the head. The head must be submitted to an approved laboratory for rabies analysis.~~ ~~(4-2-08)~~

v. Rabies susceptible animals other than domestic dogs, cats, *or* ferrets~~, or livestock~~ must be destroyed and the head submitted to an approved laboratory for rabies analysis, unless an exemption is given by the Department or Health District. ~~(3-29-10)~~*( )*

vi. No person will destroy, or allow to be destroyed, the head of a rabies-susceptible animal that has bitten *or otherwise potentially exposed* a person *to rabies* without authorization from the Department or Health District. ~~(4-2-08)~~*( )*

b. The ~~handling~~ *management* of a rabies-susceptible animal that has not bitten a person, but has ~~within the past one hundred eighty (180) days~~ been bitten, mouthed, mauled by, or closely confined in the same premises with a ~~known~~ *confirmed or suspected* rabid animal must be as follows: ~~(4-2-08)~~*( )*

i. Any exposed livestock will be referred to the Idaho State Department of Agriculture for management. *( )*

i*i*. Any domestic dog, cat, *or* ferret~~, or livestock~~ which has ~~not~~ *never* been vaccinated *against rabies* as recommended by the American Veterinary Medical Association, must be *appropriately vaccinated in accordance with guidance in the "Compendium of Animal Rabies Prevention and Control" incorporated by reference in Subsection 004.05 of these rules as soon as possible and* placed in *strict* quarantine for a period of ~~six~~ four (~~6~~4) months *(six (6) months for ferrets)* under the observation of a licensed veterinarian or a person designated by the Idaho *State* Department of Agriculture, Health District, or the Department. ~~and vaccinated according to the Rabies Compendium. An animal with current vaccinations, including livestock, should be revaccinated immediately with an appropriate rabies vaccine and quarantined for forty-five (45) days. These provisions apply only to animals for which an approved rabies vaccine is available~~ *The strict quarantine of such an animal must be within an enclosure deemed adequate by a person designated by the Idaho State Department of Agriculture, Health District, or the Department to prevent contact with any person or rabies-susceptible animal. If signs suggestive of rabies develop, immediately consult the Health District or Department to discuss euthanasia or rabies testing. Destruction of such an animal is permitted as an alternative to strict quarantine.* ~~(4-2-08)~~*( )*

~~ii. The quarantine of such animal must be within an enclosure deemed adequate by a person designated by the Idaho Department of Agriculture, the Department, or Health District to prevent contact with any person or rabies-susceptible animal.~~ ~~(4-2-08)~~

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

( )

i~~i~~v. The owner of the animal is financially responsible for the cost of ~~isolating and quarantining~~ managing and testing of the animal as described in Subsection 610.04.b. of this rule ~~and for specimen collection and testing~~. ~~(4-2-08)~~( )

~~iv. Destruction of such animal is permitted as an alternative to quarantine.~~ ~~(4-2-08)~~

c. Any rabies-susceptible animal other than domestic dogs, cats, ferrets, or livestock that are suspected of having rabies, or which have been in close contact with an animal known to be rabid, must be destroyed. The animal must be tested by an approved laboratory for rabies if a person has been bitten or has had direct contact with the animal which might result in the person becoming infected unless an exemption is granted by the Department or Health District. (3-29-10)

05. City or County Authority. Nothing in these rules is intended or will be construed to limit the power of any city or county in its authority to enact more stringent requirements to prevent the transmission of rabies. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

~~**791. -- 799. (RESERVED)**~~

~~**800. WEST NILE VIRUS (WNV).**~~

~~**01. Reporting Requirements**. Each case of West Nile virus (WNV) infection must be reported to the Department or Health District within three (3) working days of identification.~~ ~~(3-29-10)~~

~~**02. Investigation**. Each reported case of WNV infection must be investigated to confirm the diagnosis, review any travel history, review any blood donations, and identify the most likely source of infection including exposure to vectors, blood transfusion, or organ receipt.~~ ~~(4-2-08)~~

~~80~~791. -- 809. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.12 – PROCEDURES AND TESTING TO BE PERFORMED ON NEWBORN INFANTS

DOCKET NO. 16-0212-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 39-605, 39-906, 39-1603, 39-4502, and 56-1003, 56-1005, 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:

Most of the larger hospitals in Idaho perform universal Critical Congenital Heart Disease (CCHD) screening as part of the newborn screening panel. However, some of the smaller, more rural hospitals and birthing centers do not. Idaho is the only state that does not have rules that cover the requirements for CCHD screening. This rule change adds CCHD to the uniform screening panel for all newborns in Idaho. Congenital heart defects are the most common birth defect and impact approximately 8 out of every 1,000 infants born. Of these, approximately 25% (2.4 per 1,000) are considered critical and require immediate detection and intervention. In Idaho, it is estimated that approximately 55 infants are born each year with CCHD. The goal of CCHD screening is to identify and treat newborns with structural heart defects utilizing a simple, cost-effective, and noninvasive screening test where oxygen saturation is assessed after the first 24 hours of life. Without this intervention, the rates of mortality and survival with significant disability are extremely high among infants with CCHD.

This proposed rule change adds CCHD as a required screening and mandates that all newborns receive a CCHD screening shortly after birth. If the proposed rules are approved, the Department will add CCHD screening information to their birth certificate system in Vital Records. This would allow the Idaho Newborn Screening Program to monitor screening compliance and provide assistance to families including referrals for follow-up care on positive screens.

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 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 111-116**.

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:

Federal funds will be used to cover the costs associated with implementation of these rules.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Jacquie Watson at (208) 334-5963.

DATED this 16th day of November, 2017.

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 39-605, 39-906, 39-1603, 39-4502, and 56-1003, 56-1005, 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 20, 2017.

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:

Most of the larger hospitals in Idaho perform universal Critical Congenital Heart Defect (CCHD) screening as part of the newborn screening panel. However, some of the smaller, more rural hospitals and birthing centers do not. Idaho is the only state that does not have rules that cover the requirements for CCHD screening. This rule change adds CCHD to the uniform screening panel for all newborns in Idaho. Congenital heart defects are the most common birth defect and impact approximately 8 out of every 1,000 infants born. Of these, approximately 25% (2.4 per 1,000) are considered critical and require immediate detection and intervention. In Idaho, it is estimated that approximately 55 infants are born each year with CCHD. The goal of CCHD screening is to identify and treat newborns with structural heart defects utilizing a simple, cost-effective, and noninvasive screening test where oxygen saturation is assessed after the first 24 hours of life. Without this intervention, the rates of mortality and survival with significant disability are extremely high among infants with CCHD.

This proposed rule change adds CCHD as a required screening and mandates that all newborns receive a CCHD screening shortly after birth. If the proposed rules are approved, the Department will add CCHD screening information to their birth certificate system in Vital Records. This would allow the Idaho Newborn Screening Program to monitor screening compliance and provide assistance to families including referrals for follow-up care on positive screens.

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

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

An annual ongoing cost of $20,000 in general funds is projected for the Department to cover operating costs for pediatric cardiologist consultation, provider training, purchase of tool kits, and development of other educational materials. Staff time and other operating costs to implement the rules, such as the changes to the birth certificate system, will be covered annually under federal funds through the Department's Maternal and Child Health Program.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because informal stakeholder meetings are being conducted in a shorter time frame.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Critical CHD Screening Methods by the Centers for Disease Control and Prevention, from “Strategies of Implementing Screening for Critical Congenital Heart Diseases,” Kemper, et al., 2011, is being incorporated by reference into these rules to give it the force and effect of law. The document is not being reprinted in this chapter of rules due to its format.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jacquie Watson at (208) 334-5963.

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 27, 2017.

DATED this 4th day of August, 2017.

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. 16-0212-1701

001. TITLE AND SCOPE.

01. Title. The~~se rules are to be cited in full as Idaho Department of Health and Welfare Rules,~~ title of these rules is IDAPA 16.02.12, "Procedures and Testing to be Performed on Newborn Infants." ~~(7-1-10)~~( )

02. Scope. These rules specify the tests and procedures that must be performed on newborn infants for early detection of metabolic disorders, endocrine disorders, hemoglobin disorders, cystic fibrosis, critical congenital heart *disease*, and prevention of infant blindness. ~~(7-1-10)~~( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations ~~*that apply to*~~ of these rules. ~~(5-3-03)~~( )

003. ADMINISTRATIVE APPEALS.
Administrative appeals are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ~~(7-1-10)~~( )

004. INCORPORATION BY REFERENCE.
~~*Under Section 67-5229, Idaho Code, this chapter incorporates by reference the following document.*~~ The Department has incorporated by reference the following documents: ~~(7-1-10)~~( )

01. ~~*Document*~~ Blood Collection on Filter Paper for Newborn Screening Programs; Approved Standard, Fifth Edition. The Department has adopted "Blood Collection on Filter Paper for Newborn Screening Programs; Approved Standard," Fifth Edition~~.~~, Clinical and Laboratory Standards Institute~~.~~, 2007~~.~~ (ISBN 1-56238-644-1~~.~~), and hereby incorporates this standard by reference. A copy is available for review at the Department described in Section 005 of these rules, or ~~(7-1-10)~~

~~***02.*** ***Availability**. This document is available*~~ through the Clinical and Laboratory Standards Institute, 940 West Valley Road, Suite 1400, Wayne, PA 19087-1898, telephone 610-688-0100. ~~(7-1-10)~~( )

02. Critical Congenital Heart Defects (CHDs). The Department has adopted the Critical CHD Screening Methods *as recommended by the American Academy of Pediatrics*, from "Strategies of Implementing Screening for Critical Congenital Heart Diseases," Kemper, et al., 2011, and hereby incorporates this material by reference. Copies may be obtained from the Department described in Section 005 of these rules, or online at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ( )

005. OFFICE – OFFICE HOURS – MAILING ADDRESS AND STREET ADDRESS.

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. (7-1-10)

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. (7-1-10)

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State St., Boise, Idaho 83702. (7-1-10)

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (7-1-10)

05. Internet Website. ( )

a. The Department's internet website is http://www.healthandwelfare.idaho.gov. (7-1-10)

b. The Department's internet website for newborn screening is http://www.nbs.dhw.idaho.gov. ( )

(BREAK IN CONTINUITY OF SECTIONS)

010. DEFINITIONS.
The following definitions will apply in the interpretation and enforcement of this chapter: (5-3-03)

01. Critical Congenital Heart *Disease* (CCHD). CCHD, also known as critical congenital heart *defects*, is a term that refers to a group of serious heart defects, as defined by the *Centers for Disease Control and Prevention* (CDC), that are present from birth. ( )

0~~1~~2. **Department**. The Idaho Department of Health and Welfare. (5-3-03)

0~~2~~3. **Dried Blood Specimen**. A blood specimen obtained from an infant by means of skin puncture, not by means of venipuncture or any other method, that is placed on special filter paper and allowed to dry. (7-1-10)

0~~3~~4. **Hyperalimentation**. The administration of an amount of nutrients beyond minimum normal requirements of the appetite, in an attempt to replace nutritional deficiencies. (7-1-10)

0~~4~~5. **Laboratory**. A medical or diagnostic laboratory certified according to the provisions of the Clinical Laboratory Improvement Amendments of 1988 by the United States Department of Health and Human Services. (5-3-03)

0~~5~~6. **Newborn Screening**. Newborn screening means a laboratory procedure performed on dried blood specimens from newborns to detect those at risk for the diseases specified in Subsection 100.01 of these rules. (5-3-03)

0~~6~~7. **Person Responsible for Registering Birth of Child**. The person responsible for preparing and filing the certificate of birth is defined in Section 39-255, Idaho Code. (5-3-03)

08. Pulse Oximetry. A non-invasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen using equipment approved by the U.S. Food and Drug Administration for use with newborn infants. ( )

0~~7~~9. **Test Kit**. The materials provided by the laboratory for the purposes of dried blood specimen collection and submission of specimens for newborn screening laboratory procedures. (5-3-03)

011. -- 049. (RESERVED)

050. USE AND STORAGE OF DRIED BLOOD SPECIMENS.

01. Use of Dried Blood Specimens. Dried blood specimens will be used for the purpose of testing the infant from whom the specimen was taken, for congenital birth defects. Limited use of specimens for routine calibration of newborn screening laboratory equipment and quality assurance is permissible. (7-1-10)

02. Prohibited Use of Dried Blood Specimens. Dried blood specimens may not be used for any purpose other than those described in Subsection 050.01 of this rule without the express written consent of the parent(s) or guardian(s) of the infant from whom the specimen was collected. ~~(7-1-10)~~( )

03. Storage of Dried Blood Specimens. Dried blood specimens may be stored at the testing facility for a period not to exceed eighteen (18) months. Acceptable use of stored specimens will be for re-testing the specimen in the event of a symptomatic diagnosis or death of the infant during the storage period. (7-1-10)

051. -- 099. (RESERVED)

100. DUTIES OF THE ADMINISTRATOR OF THE RESPONSIBLE INSTITUTION AND THE PERSON REQUIRED TO REGISTER THE BIRTH OF A CHILD.

01. Conditions for Which Infants Will Be Tested. All infants born in Idaho must be tested for at least the following conditions: (7-1-10)

a. Biotinidase deficiency; (5-3-03)

b. Congenital hypothyroidism; (5-3-03)

c. Galactosemia; (5-3-03)

d. Maple syrup urine disease; ~~and~~ ~~(5-3-03)~~( )

e. Phenylketonuria~~.~~; and ~~(5-3-03)~~( )

f. Critical congenital heart *disease*. ( )

02. Blood Specimen Collection. (5-3-03)

a. The dried blood specimen collection procedures must follow the document listed in Subsection 004.01 of these rules. (7-1-10)

b. For infants admitted to the neonatal intensive care unit (NICU), the initial dried blood specimen for newborn screening must be obtained upon admission to the NICU. (7-1-10)

c. For non-premature infants, in-hospital, the initial dried blood specimen for newborn screening must be obtained between twenty-four (24) and forty-eight (48) hours of age. (7-1-10)

d. For newborns transferred from one hospital to another, the originating hospital must assure that the dried blood specimen is drawn. If the newborn is too premature or too sick to have a dried blood specimen drawn for screening prior to transfer and a dried blood specimen is not obtained, the originating hospital must document this, and notify the hospital to which the newborn is being transferred that a dried blood specimen for newborn screening has not been obtained. (7-1-10)

e. Prior to the discharge of an infant from the institution where initial newborn care or specialized medical care was rendered, the Administrator of the institution must assure that an adequate dried blood specimen has been collected regardless of the time the infant is discharged from the institution. (7-1-10)

f. For births occurring outside of a hospital, the birth attendant is responsible for assuring that an acceptable dried blood specimen is properly collected for newborn screening as stipulated in Section 100 of these rules. (7-1-10)

g. Newborns who require a blood transfusion, hyperalimentation, or dialysis must have a dried blood specimen collected for screening prior to these procedures. (7-1-10)

h. If a dried blood specimen cannot be obtained for newborn screening before transfusion, hyperalimentation, or dialysis, the hospital must ensure that a repeat dried blood specimen is obtained at the appropriate time when the specimen will reflect the infant's own metabolic processes and phenotype. (7-1-10)

i. All infants must be retested. A test kit must be given to the parents or responsible party at the time of discharge from the institution where initial newborn care was rendered, with instructions to have a second dried blood specimen collected. The preferred time for sample collection is between ten (10) and fifteen (15) days of age. (7-1-10)

03. Specimen Data Card. The person obtaining the newborn screening specimen must complete the demographic information card attached to the sample kit. The First Specimen Card must include the infant's mother's date of birth, address, and phone number. Both the First and Second Specimen's Card must include the items listed in 100.03.a. through 100.03.k. of this rule, optional fields may be completed as needed. (7-1-10)

a. Name of the infant; (7-1-10)

b. Whether the birth was a single or multiple-infant birth; (7-1-10)

c. Name of the infant's mother; (7-1-10)

d, Gender of the infant; (7-1-10)

e. Method of feeding the infant; (7-1-10)

f. Name of the birthing facility; (7-1-10)

g. Date and time of the birth; (7-1-10)

h. Date and time the specimen was obtained; (7-1-10)

i. Name of the attending physician or other attendant; (7-1-10)

j. Date specimen was collected; and (7-1-10)

k. Name of person collecting the specimen. (7-1-10)

04. Specimen Mailing. Within twenty-four (24) hours after collection, the dried blood specimen must be mailed to the laboratory by first class mail or its equivalent, except when mailing service is not available. When mailing service is not available on weekends and holidays, dried blood specimens must be mailed to the laboratory on the first available mail pick-up day. The preferred method of mailing, following a weekend or holiday, is by expedited mail service. (7-1-10)

05. Record Keeping. Maintain a record of all dried blood specimens collected for newborn screening. This record must indicate: (7-1-10)

a. Name of the infant; (7-1-10)

b. Name of the attending physician or other attendant; (7-1-10)

c. Date specimen was collected; and (7-1-10)

d. Name of person collecting specimen. (7-1-10)

06. Collection Protocol. Ensure that a protocol for collection and submission for newborn screening of adequate dried blood specimens has been developed, documented, and implemented. Individual responsibilities must be clearly defined and documented. The attending physician must request that the test be done. The hospital may make an appropriate charge for this service. (7-1-10)

07. Responsibility for Recording Specimen Collection. (5-3-03)

a. The administrator of the responsible institution, or his designee, must record on the birth certificate whether the dried blood specimen for newborn screening has been collected. (7-1-10)

b. When a birth occurs outside a hospital, the person responsible for registering the birth of the child must record on the birth certificate whether the dried blood specimen for newborn screening has been collected and submitted within twenty-four (24) hours following collection. (7-1-10)

08. Fees. The Department will provide access to newborn screening laboratory services. If the administration of the responsible institution or the person required to register the birth of a child chooses to utilize this service, the Department will collect a fee equal to the cost of the test kit, analytical, and diagnostic services provided by the laboratory. The fees must be remitted to the Department before the laboratory provides the test kit to those responsible for ensuring the infant is tested according to these rules. (7-1-10)

(BREAK IN CONTINUITY OF SECTIONS)

301. NEWBORN CRITICAL CONGENITAL HEART *DISEASE* (CCHD) SCREENING.

01. Pulse Oximetry for the Screening of CCHD. ( )

a. For births occurring in a hospital, the administrator of the institution or his designee must assure that all infants who meet the CDC criteria for CCHD screening are screened following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ( )

b. For births occurring outside of a hospital, the birth attendant must assure that screening for congenital heart *disease* is conducted through the use of pulse oximetry *no sooner than twenty-four (24) hours after birth and no later than forty-eight (48) hours after birth* following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ( )

02. Responsibility of Recording CCHD Screening Results. ( )

a. For births occurring in a hospital, the administrator of the responsible institution or his designee must record *the pulse oximetry results* on the birth certificate *and* whether the CCHD screening was *determined* as "passed" or "failed" following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html, or "not screened." ( )

b. For births occurring outside of a hospital, the *birth attendant or his designee* must record *the pulse oximetry results* on the birth certificate *and* whether the CCHD screening was *determined* as "passed" or "failed" following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html, or "not screened." ( )

03. Follow Up for Abnormal CCHD Screening Results. ( )

a. For births occurring in a hospital, the administrator of the responsible institution or his designee must make a referral for further evaluation of the newborn whose CCHD results are abnormal and inform the parent

or legal guardian of the need for appropriate intervention. ( )

b. For births occurring outside of a hospital, the person performing the screening is responsible for making an immediate referral for further evaluation of the newborn whose CCHD results are abnormal and informing the parent or legal guardian of the need for appropriate intervention. ( )

30~~1~~2. -- 399. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.01 – ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2018. The pending rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 and is also adopting a temporary rule. 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, 56-260 through 56-266, Idaho Code; and House Bill 43 (2017).

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 and a statement of any change between the text of the proposed rule and the text of the pending rule:

As part of the Jeff D settlement agreement and the adoption of HB 43 (2017) that is directly related to it, the Department has created the Youth Empowerment Services (YES) Medicaid program that will provide medical assistance and respite care services to youth diagnosed with Serious Emotional Disturbance (SED). The Division of Welfare will be determining the non-financial and financial eligibility components of the program. This rule change adds guidance around the eligibility criteria that a participant must meet to be eligible for services under the YES program. This is a companion rule to Docket Nos. 16-0310-1706, 16-0318-1701, and 16-0737-1701 publishing in this Bulletin.

Corrections were made to the citations to IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," to reflect the amendments to the pending rule made to Docket No. 16-0310-1706.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice and includes changes made to the pending rule. The text of the pending rule has been modified in accordance with Section 67-5227, Idaho Code. The complete text of the proposed rule was published in the October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 231 and 232**.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule confers a benefit in the form of new services. These new services are being called Youth Empowerment Services (YES), and several other chapters of rules are implementing changes with the same effective date of January 1, 2018, to meet the intent of the law and the court-ordered settlement agreement.

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 for this rulemaking to the State General Fund, or any other funds as eligibility will be determined for this program in conjunction with already existing Medicaid programs through the automated eligibility system.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending and temporary rule, contact Camille Schiller at (208) 334-5969.

DATED this 3rd day of November, 2017.

Tamara Prisock, DHW – Administrative Rules Unit
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: **dhwrules@dhw.idaho.gov**

450 W. State Street – 10th Floor
Boise, ID 83720-0036
P.O. Box 83720

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, Idaho Code; and House Bill 43 (2017).

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

PUBLIC HEARING
Wednesday, October 18, 2017 — 9:00 a.m. (Local)

Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

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

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

As part of the Jeff D settlement agreement and the adoption of HB 43 (2017) that is directly related to it, the Department has created the Youth Empowerment Services (YES) Medicaid program that will provide medical assistance, respite care, and transportation services to youth diagnosed with Severe Emotional Disturbance (SED). The Division of Welfare will be determining the non-financial and financial eligibility components of the program. Specifically, this rule change adds guidance around the eligibility criteria that a participant must meet to be eligible for services under the YES program. This is a companion rule to Docket No. 16-0310-1706 and Docket No. 16-0318-1701 publishing in this Bulletin.

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

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

There is no anticipated fiscal impact for this rulemaking to the State General Fund, or any other funds as eligibility will be determined for this program in conjunction with already existing Medicaid programs through the automated eligibility system.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because negotiated rulemaking was not feasible since these rule changes are not negotiable as the benefits included herein are court-ordered through the Jeff D settlement agreement.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Camille Schiller at (208) 334-5969.

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 27, 2017.

DATED this 1st day of September, 2017.

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. 16-0301-1701

540. YOUTH EMPOWERMENT SERVICES (YES) PROGRAM CHILDREN.

01. Payments for Children Under Eighteen (18) Years of Age with SED. In accordance with Section 56-254(2), Idaho Code, the Department will make payments for medical assistance for a child under eighteen (18) years of age with serious emotional disturbance (SED), as defined in Section 16-2403, Idaho Code, and verified by an independent assessment: ( )

a. Whose family income does not exceed three hundred percent (300%) of the federal poverty guideline (FPG) as determined using MAGI-based eligibility standards; and ( )

b. Who meets other eligibility standards in accordance with the rules of the Department. ( )

02. Youth Empowerment Services (YES) Benefits. Applicants whose family income is equal to or less three hundred percent (300%) of the Federal Poverty Guidelines (FPG) for children zero (0) to eighteen (18) years of age and who meet the non-financial eligibility criteria in Sections 200 through 299 of these rules may receive the following benefits: ( )

a. Youth Empowerment Services (YES) State Plan option services and supports described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 6*38*; and *( )*

b. Additional covered services set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 075 through 799. ( )

03. Additional Eligibility Criteria and Program Requirements for YES. Additional eligibility criteria and program requirements applicable to the Youth Empowerment Services (YES) State Plan option are described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 6*38*. *( )*

54~~0~~1. -- 544. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.01 – ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-1702

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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, 56-203, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 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 certain areas of eligibility for specialized populations. While the proposed changes are minor, they will greatly add to the understanding of the intent of the program administration for children under a certain adoptive category for citizenship purposes, foster children who are seeking benefits, and pregnant women needing post-partum 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 October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 233 through 236**.

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 average annual fiscal impact is projected to be $53,361 (based on an average of $441/woman x 121 women who fit into this scenario last fiscal year). This will be split into approximately $15,300 from state general funds and $38,100 from federal funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Camille Schiller at (208) 334-5969.

DATED this 16th day of November, 2017.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
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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, 56-209, 56-236 through 56-240, 56-242, 56-250 through 56-257, 56-260 through 56-266, 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 18, 2017.

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 certain areas of eligibility for specialized populations. While the proposed changes are minor, they will greatly add to the understanding of the intent of the program administration for children under a certain adoptive category for citizenship purposes, foster children who are seeking benefits, and pregnant women needing postpartum services.

The following rule changes are being made:

1. An exception is being added to restrict certain foreign-born children's eligibility due to a particular adoption code;

2. A provision is being removed that would inadvertently prevent pregnant women to receive postpartum services regardless of when they apply for benefits during or after their pregnancy ends; and

3. A clarification is being added to rules regarding Title XIX foster care Medicaid to explain when certain eligibility criteria should be used.

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

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

The fiscal impact associated with this rule change is minimal to none. An analysis conducted by the Division of Medicaid concluded any potential impact is so minimal that requesting additional funds is not warranted at this time.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the proposed rule changes simply clarify current Department practices and do not change eligibility determinations for customers. Stakeholders will not be affected by these changes.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Camille Schiller at (208) 334-5969.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-1702

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, and the child does not have IR-4 status; ~~(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. 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 221.13 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. (3-25-16)

(BREAK IN CONTINUITY OF SECTIONS)

500. PREGNANT WOMAN COVERAGE.
A pregnant woman of any age is eligible for the Pregnant Woman coverage if she meets all of the non-financial and financial criteria of the coverage group. Health care assistance for Pregnant Woman coverage is limited to pregnancy-related and postpartum services. The Pregnant Woman medical assistance coverage extends through the sixty (60)

day postpartum period if she ~~applied for medical assistance while pregnant and~~ was eligible to receive ~~receiving~~ medical assistance when the child was born. ~~An individual who applies for Pregnant Woman medical assistance after the child is born is not eligible for the sixty-day (60) postpartum period.~~ ~~(3-20-14)~~( )

01. Income Limit. The individual's calculated income must not exceed one hundred thirty-three percent (133%) of the Federal Poverty Guidelines (FPG) for her family size in the application month. (3-20-14)

02. Household Size. The household budget unit consists of the pregnant woman, the unborn child or children if expecting more than one (1) child, and any individual determined to be part of the household budget unit based on MAGI methodologies as identified in Sections 300 through 303, and 411 of these rules. (3-20-14)

03. Income Disregards. A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) for family size is applied to the MAGI income of the pregnant woman if the disregard is necessary to establish income eligibility. (3-20-14)

04. Continuing Eligibility. The pregnant woman remains eligible during the pregnancy regardless of changes in income. The woman must report the end of pregnancy to the Department within ten (10) days. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

535. TITLE IV-E FOSTER CARE CHILD.
A child may be eligible for ~~Health Care Assistance as a~~ Medicaid under the Title IV-E foster care ~~child~~ program if they ~~following conditions are~~ meet the eligibility requirements in IDAPA 16.06.01, "Child and Family Services," Section 425. ~~(3-20-14)~~( )

~~**01. Court Order or Voluntary Placement**. The child must have been living in a parent's or relative's home during the month a court order removes the child or during the month a parent or relative voluntarily signs a written agreement with the Department for foster care. (3-20-14)~~

~~**02. Custody and Placement**. The child's placement and care are the Department's responsibility and the child is living in a licensed foster home, licensed institution, licensed group home, detention center, or in a relative's home approved for the child by the Department. (3-20-14)~~

~~**03. IV-E Foster Care and SSI Eligibility**. When a child is eligible for both IV-E Foster Care and SSI, the caretaker relative or social worker must choose the Medicaid coverage group for the child. (3-20-14)~~

536. TITLE XIX FOSTER CHILD.
A child ~~living in a foster home, children's agency, or children's institution~~ who does not meet the conditions of Title IV-E Foster Care may be Medicaid eligible if the ~~following conditions are met:~~ child meets the non-financial and financial requirements to be eligible for Title XIX Medicaid as a categorically eligible child under regular MAGI-based methodology. ~~(3-20-14)~~( )

~~**01. Age**. The foster child is under age twenty-one (21). (3-20-14)~~

~~**02. Department Responsibility**. The Department assumes full or partial financial responsibility for the child. (3-20-14)~~

~~**03. Calculated Income**. The child's calculated income is: (3-20-14)~~

~~**a.** Two hundred thirty-three dollars ($233) or less; and (3-20-14)~~

~~**b.** If necessary, a standard disregard of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the child's calculated income in order for the child to be eligible for coverage. (3-20-14)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.05 – RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED (AABD)

DOCKET NO. 16-0305-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 56-202, 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:

The Department is amending the proposed rules to remove the Personal Needs Allowance (PNA) and Personal Needs Supplement (PNS) increases for Medicaid participants living in nursing homes. All other proposed rule changes are being adopted as proposed.

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 4, 2017, Idaho Administrative Bulletin, **Vol.17-10, pages 237 through 246**.

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

The fiscal impact for SFY 2019 regarding Personal Needs Allowance (PNA) and Personal Needs Supplement (PNS) for Medicaid participants living in nursing homes is being removed, as the increases in those rules are being removed from the pending rules. The pending changes that remain in these rules are cost-neutral and will have no fiscal impact to state or federal funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Camille Schiller at (208) 334-5969.

DATED this 16th day of November, 2017.

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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 56-202, 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 18, 2017.

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 amending this chapter of rules for the following updates:

1. The Cash Assistance program is being clarified for the AABD population who receive Social Security Income (SSI) as the only eligible participants.

2. The asset transfers and annuities are being aligned with federal regulations and guidance.

3. Personal Needs Allowance and Personal Needs Supplement amount is being increased for individuals living in a nursing home facilities.

4. The Basic Needs Allowance calculation explanation for RALFs and CFHs is being amended.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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 fiscal impact for SFY 2019 increase for the Personal Needs Allowance (PNA) for Medicaid participants is estimated to be a total impact of $486,600 of which $347,600 is federal funds (71.433%), and $139,000 is state general funds (28.567%). Additionally, the Personal Needs Supplement for individuals receiving SSI income below $55 PNA is estimated to be $35,800 that is from state general funds. Other changes being made to these rules are cost-neutral and will have no fiscal impact to state or federal funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted for the Personal Needs Allowance (PNA) for Medicaid participants living in nursing homes. The Notice of Negotiated Rulemaking published in the July 5, 2017, Idaho Administrative Bulletin, **Vol. 17-7, page 54**. The Department determined it was not feasible to negotiate rule changes that align with federal regulations and are not negotiable.

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 Camille Schiller at (208) 334-5969.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-1701

051. EFFECTIVE DATE.
The effective date for aid is the first day of the month of application. Medicaid eligibility begins as described in Subsections 051.01 through 051.04. (7-1-99)

01. AABD Cash *~~and Participant Required to Apply for SSI~~*. *~~When the participant is required to apply for SSI as a condition of AABD cash, the effective date of the AABD cash is the first month the participant gets an SSI payment. If the participant is not eligible for SSI but is eligible for~~* AABD cash~~,~~ aid is effective on the application date. *~~(7-1-99)~~*( )

02. Normal Medicaid Eligibility. Medicaid coverage begins on the first day of the application month. (7-1-99)

03. Retroactive (Backdated) Medicaid Eligibility. Medicaid benefits must be backdated to the first day of the calendar month, for each of the three (3) months before the month of application, if the participant was Medicaid eligible during that month. If the participant is not eligible for Medicaid when he applies, retroactive eligibility is evaluated. (7-1-99)

04. Ineligible Non-Citizen Medicaid. Ineligible legal or illegal non-citizen coverage is restricted to emergency services. Coverage begins when the emergency treatment is required. Coverage ends with the last day emergency treatment is required. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

279. RETIREMENT FUNDS.
Retirement funds are *~~annuities or~~* work-related plans for providing income or pensions when employment ends. A retirement fund, owned by a participant, is a resource if he has the option of withdrawing a lump sum, even though he is not yet eligible for periodic retirement payments. If the participant is eligible for periodic retirement payments, the fund is not a countable resource. The value of a retirement fund is the amount of money a participant can currently withdraw from the fund. *~~(7-1-99)~~*( )

(BREAK IN CONTINUITY OF SECTIONS)

513. RESIDENTIAL CARE OR ASSISTED LIVING FACILITY AND CERTIFIED FAMILY HOME ALLOWANCES.
A participant living in a Residential Care or Assisted Living Facility (RALF), in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," or a Certified Family Home (CFH), in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," is budgeted a basic allowance of *~~seventy-seven~~* ninety-six dollars ($*~~77~~*96) monthly. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment

will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. ~~(7-1-13)~~( )

01. Budgeted Monthly Allowance Based On Level of Care. A participant is budgeted a monthly allowance for care based on the level of care received as described in Section 515 of these rules. If the participant does not require State Plan Personal Care Services (PCS), his eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. (4-7-11)

02. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 of these rules. Beginning July 1, 2013, the RALF and CFH allowances for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded to the next dollar.

TABLE 513.02 - STATE PLAN PCS CARE LEVELS AND ALLOWANCES AS OF 1-1-06

	Level of Care	Monthly Allowance
a.	Level I	Eight hundred and thirty-five dollars ($835)
b.	Level II	Nine hundred and two dollars ($902)
c.	Level III	Nine hundred and sixty-nine dollars ($969)

(7-1-13)

03. CFH Operated by Relative. A participant living in a Certified Family Home (CFH) operated by his parent, child or sibling is not entitled to the CFH State Plan PCS allowances. He may receive the allowance for a person living with a relative as described in Section 501 of these rules. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent or grandchild by birth, marriage, or adoption. (3-30-17)

(BREAK IN CONTINUITY OF SECTIONS)

781. RSDI RECIPIENT ENTITLED TO COLA DISREGARD.
A participant receiving RSDI is eligible for Medicaid if he became and remains ineligible for SSI payments as of April 2011, or for AABD cash or SSI payments ~~after April,~~ from May 1977 through March 2011. The participant must still be entitled to AABD cash or SSI, except for a cost-of-living adjustment (COLA) in RSDI benefits. All RSDI COLAs received by the participant, and any person whose income and resources are counted in determining the participant's eligibility, are disregarded for Medicaid. ~~(7-1-99)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

841. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.
A participant is not subject to the asset transfer penalty for taking any action described in Subsections 841.01 through 841.14 of this rule. (4-2-08)

01. Home to Spouse. The asset transferred was a home. Title to the home was transferred to the spouse. (7-1-99)

02. Home to Minor Child or Disabled Adult Child. The asset transferred was a home. Title to the home was transferred to the child of the participant or spouse. The child must be under age twenty-one (21) or blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-99)

03. Home to Brother or Sister. The asset transferred was a home. Title to the home was transferred to a brother or sister of the participant or spouse. The brother or sister must have an equity interest in the transferred home. The brother or sister must reside in that home for at least one (1) year immediately before the month the participant starts long-term care. (7-1-99)

04. Home to Adult Child. The asset transferred was a home. Title to the home was transferred to a son or daughter of the participant or spouse, other than a child under the age of twenty-one (21). The son or daughter must reside in that home for at least two (2) years immediately before the month the participant started long-term care. The adult child must prove he provided nursing facility level medical care to the participant which permitted him to live at home rather than enter long-term care. The son or daughter must not have received payment from Medicaid for home and community based services provided to the participant. (4-2-08)

05. Benefit of Spouse. The assets were transferred to the participant's spouse or to another person for the sole benefit of the spouse. (7-1-99)

06. Transfer From Spouse. The assets were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. (7-1-99)

07. Transfer to Child. The assets were transferred to the participant's child, or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. (7-1-99)

08. Intent to Get Fair Market Value. The participant or spouse proves he intended to dispose of the assets at fair market value or for other adequate consideration. (7-1-99)

09. Assets Returned. All assets transferred for less than fair market value have been returned to the participant. (7-1-99)

10. Medicaid Qualification Not the Intent. The participant or spouse proves the assets were transferred exclusively for a purpose other than to qualify for Medicaid or to avoid recovery. (3-20-04)

11. Undue Hardship. The participant, his representative, or the facility in which he resides may request the hardship waiver. The hardship waiver must be requested in writing within ten (10) days of the date of the asset transfer penalty notice. Undue hardship exists if any of the conditions in Subsections 841.11.a. through 841.11.d. of this rule apply. (4-2-08)

a. The participant proves he is not able to pay for his nursing facility services or his wavier services by any means. (3-30-07)

b. The participant proves that he has made reasonable efforts, consistent with his physical and financial ability, to recover the transferred asset. The participant must fully cooperate with the state of Idaho in efforts to recover the transferred asset and, upon request, must assign his rights to recover the asset to the State of Idaho. (3-30-07)

c. The participant proves he did not knowingly transfer the asset. (3-30-07)

d. The participant proves he would be deprived of food, clothing, shelter or other necessities of life if the asset transfer penalty is imposed and he assigns his rights to recover the asset to the State of Idaho. (3-30-07)

12. Exception to Fair Market Value. The amount received is adequate, even if not fair market value. This exception must meet one (1) of the conditions in Subsections 841.12.a. through 841.12.c. of this rule. (4-2-08)

a. A forced sale was done under reasonable circumstances. (7-1-99)

b. Little or no market demand exists for the type of asset transferred and the lack of market demand was not created by a voluntary act of the participant to qualify for assistance or to avoid recovery. (4-2-08)

c. The asset was transferred to settle a legal debt approximately equal to the fair market value of the transferred asset. (7-1-99)

13. No Benefit to Participant. The participant received no benefit from the asset. This exception must meet one (1) of the conditions in Subsections 841.13.a. and 841.13.b. of this rule. (4-2-08)

a. The participant or spouse held title to the property only as a trustee for another person. The participant or spouse had no beneficial interest in the property. (7-1-99)

b. The transfer was done to clear title to property. The participant or spouse had no beneficial interest in the property. The defect in the title was not created in an attempt to transfer assets to qualify for assistance or avoid recovery. (3-30-07)

14. Fraud Victim. The asset was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the assets or property, or its equivalent in damages and must assign recovery rights to the state of Idaho. (3-20-04)

15. Transfer to Trust of Disabled Person. The assets were transferred to a trust established solely for the benefit of an individual under sixty-five (65) years of age who is disabled. ( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.08 – RULES GOVERNING THE TEMPORARY ASSISTANCE FOR FAMILIES IN IDAHO (TAFI) PROGRAM

DOCKET NO. 16-0308-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the 2018 legislative session unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 56-202, Idaho Code, and 45 CFR Parts 260-265.

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 amended these rules relating to:

1. Children receiving Supplemental Security Income (SSI) income when their families apply for and receive TAFI benefits; and
2. A child's eligibility when the child turns eighteen (18) years old.

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 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 247-252**.

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:

1. The fiscal impact for a child who receives Supplemental Security Income (SSI), is cost-neutral.
2. The fiscal impact related to the change in regards to the eligibility of a TAFI household with a child turning eighteen (18) is between $2,000 and $6,000 in cost savings. The state general fund portion is $650 and $1,950, and the federal funds portion is $1,350 and $4,050.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Ericka Rupp at (208) 334-5641.

DATED this 3rd day of November, 2017.

Tamara Prisock
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202, Idaho Code, and 45 CFR Parts 260-265.

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 18, 2017.

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 amending these rules relating to:

1. Children receiving Supplemental Security Income (SSI) income when their families apply for and receive TAFI benefits; and

2. A child's eligibility when the child turns eighteen (18) years old.

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

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

1. The fiscal impact for a child who receives Supplemental Security Income (SSI), is anticipated to be cost-neutral.

2. The fiscal impact related to the change being made in regards to the eligibility of a TAFI household with a child turning eighteen (18) is estimated to be between $2,000 and $6,000 in cost savings. The state general fund portion would be $650 and $1,950, and the federal funds portion would be $1,350 and $4,050.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Negotiated Rulemaking published in the July 5, 2017, Idaho Administrative Bulletin, **Vol. 17-7, page 55**.

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 Ericka Rupp at (208) 334-5641.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0308-1701

010. DEFINITIONS.

01. Agency Error. A benefit error caused by the Department's action or failure to act. (7-1-12)

02. Applicant. An individual who applies for Temporary Assistance for Families in Idaho. (7-1-98)

03. Assistance. Cash payments, vouchers, and other benefits designed to meet a family's ongoing basic needs. Assistance includes recurring benefits, such as transportation and child care, conditioned on participation in work activities. (3-30-01)

04. Caretaker Relative. An adult who is a specified relative, other than parents, who has an eligible related child residing with them and who is responsible for the child's care. Only one (1) child in the family must be related to one (1) of the following specified relatives: brother, sister, aunt/great aunt, uncle/great uncle, grandparent/great grandparent, nephew, niece, cousin, any one (1) of these relationships by half-blood, a step-sibling, or a spouse of a relative by marriage, even if the marriage has ended. (3-29-17)

05. Claim Determination. The action taken by the Department establishing the household's liability for repayment when a TAFI overpayment occurs. (7-1-12)

06. Department. The Idaho Department of Health and Welfare. (7-1-98)

07. Dependent Child. A child under the age of eighteen (18)~~, or under the age of nineteen (19) and attending, full time, a secondary school or the equivalent level of vocational or technical training~~. ~~(3-30-01)~~( )

08. Earned Income. Cash or in-kind payment derived from employment or self-employment. Receipt of a service, benefit or durable goods instead of wages is in-kind income. Earned income is gross earnings before deductions for taxes or any other purposes. (7-1-98)

09. Family. A family is an eligible individual or group of eligible individuals living in a common residence, whose income and resources are considered in determining eligibility. Spouses living together in a common residence are considered a family. Unrelated adults who are the parents of a common child are considered a family. Adult relatives who reside together are considered separate families. Unrelated families living in a common residence are considered separate families. (3-30-01)

10. Good Cause. The conduct of a reasonably prudent person in the same or similar circumstances, unless otherwise defined in these rules. (7-1-98)

11. Household. A unit of eligible individuals that includes parents, or may include caretaker relatives who have an eligible child residing with them. (3-29-17)

12. Inadvertent Household Error (IHE). A benefit error caused unintentionally by the household. (7-1-12)

13. Noncustodial Parent. A parent legally responsible for the support of a dependent minor child, who does not live in the same household as the child. (3-30-01)

14. **Parent**. The mother/step-mother or father/step-father of the dependent child. In Idaho, a man is presumed to be the child's father if he is married to the child's mother at the time of conception or at the time of the child's birth. (3-29-17)

15. **Participant**. An individual who has signed a Personal Responsibility Contract. (7-1-98)

16. **Personal Responsibility Contract (PRC)**. An agreement negotiated between a family and the Department that is intended to result in self-reliance. (7-1-98)

17. **Temporary Assistance for Families in Idaho (TAFI)**. Idaho's family assistance program. TAFI replaced the Aid to Families With Dependent Children (AFDC) program. (3-30-01)

18. **Temporary Assistance for Needy Families (TANF)**. The Federal block grant provided to Idaho and used to fund TAFI. TANF funds other programs and services, including career enhancement and emergency assistance. (3-30-01)

19. **Unearned Income**. Income received from sources other than employment or self-employment, such as Social Security, unemployment insurance, and workers' compensation. (7-1-98)

(BREAK IN CONTINUITY OF SECTIONS)

125. MANDATORY TAFI HOUSEHOLD MEMBERS.
Individuals who must be included in the family are listed in Subsections 125.01 through 125.04 of this rule. (7-1-12)

01. **Children**. Children under the age of eighteen (18) ~~*or, under the age of nineteen (19) if they are attending a secondary school full time. Children*~~ must reside with a parent or caretaker relative who exercises care and control of them. A dependent child's brother or sister, including half (1/2) siblings, living in the same home as the dependent child must be included in the family. Children receiving Supplemental Security Income (SSI) are excluded from the household ~~*(3-29-17)*~~( )

02. **Parents**. Parents, as defined in Section 010 of these rules, who have an eligible child residing with them. (3-29-17)

03. **Pregnant Woman**. A pregnant woman with no other children who is in at least the third calendar month before the baby is due and is unable to work due to medical reasons. (4-5-00)

04. **Spouses**. Anyone related by marriage to another mandatory household member. (7-1-12)

(BREAK IN CONTINUITY OF SECTIONS)

215. EXCLUDED INCOME.
The types of income listed in Subsections 215.01 through 215.~~38~~40 of this rule, are excluded. ~~*(4-7-11)*~~( )

01. **Supportive Services**. Supportive services payments. (7-1-98)

02. **Work Reimbursements**. Work-related reimbursements. (7-1-98)

03. **Child's Earned Income**. Earned income of a dependent child, who is attending school. (7-1-98)

04. **Child Support**. Child support payments assigned to the State and non-recurring child support payments received in excess of that amount. (7-1-98)

05. **Child's Supplemental Security Income**. A child's Supplemental Security Income (SSI). ( )

05~~6~~. **Loans**. Loans with a signed, written repayment agreement. (7-1-98)

06~~7~~. **Third Party Payments**. Payments made by a person directly to a third party on behalf of the family. (7-1-98)

07~~8~~. **Money Gifts**. Money gifts, up to one hundred dollars ($100), per person per event, for celebrations typically recognized with an exchange of gifts. (7-1-98)

08~~9~~. **TAFI**. Retroactive TAFI grant corrections. (7-1-98)

0910. **Social Security Overpayment**. The amount withheld for a Social Security overpayment. Money withheld voluntarily or involuntarily to repay an overpayment from any other source is counted as income. (7-1-99)

10~~1~~. **Interest Income**. Interest posted to a bank account. (7-1-98)

11~~2~~. **Tax Refunds**. State and federal income tax refunds. (7-1-98)

12~~3~~. **EITC Payments**. EITC payments. (7-1-98)

13~~4~~. **Disability Insurance Payments**. Taxes withheld and attorney's fees paid to secure disability insurance payments. (7-1-98)

14~~5~~. **Sales Contract Income**. Taxes and insurance costs related to sales contracts. (7-1-98)

15~~6~~. **Foster Care**. Foster care payments. (7-1-98)

16~~7~~. **Adoption Assistance**. Adoption assistance payments. (7-1-98)

17~~8~~. **Food Programs**. Commodities and food stamps. (7-1-98)

18~~9~~. **Child Nutrition**. Child nutrition benefits. (7-1-98)

1920. **Elderly Nutrition**. Elderly nutrition benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965. (7-1-98)

20~~1~~. **Low Income Energy Assistance**. Benefits paid under the Low Income Energy Assistance Act of 1981. (7-1-98)

21~~2~~. **Home Energy Assistance**. Home energy assistance payments under Public Law 100-203, Section 9101. (7-1-98)

22~~3~~. **Utility Reimbursement Payment**. Utility reimbursement payments. (7-1-98)

23~~4~~. **Housing Subsidies**. An agency or housing authority pays a portion of or all of the housing costs for a participant. (5-8-09)

24~~5~~. **Housing and Urban Development (HUD) Interest**. Interest earned on HUD family self-sufficiency escrow accounts established by Section 544 of the National Affordable Housing Act. (7-1-98)

25~~6~~. **Native American Payments**. Payments authorized by law made to people of Native American ancestry. (7-1-98)

26~~7~~. **Educational Income**. Educational income includes deferred repayment education loans, grants, scholarships, fellowships, and veterans' educational benefits. The school attended must be a recognized institution of post secondary education, a school for the handicapped, a vocational education program, or a program providing completion of a secondary school diploma, or equivalent. (7-1-12)

2~~7~~8. **Work Study Income of Student**. College work study income. (7-1-98)

2~~8~~9. **VA Educational Assistance**. VA Educational Assistance. (7-1-98)

~~29~~30. **Senior Volunteers**. Senior volunteer program payments to individual volunteers under the Domestic Volunteer Services Act of 1979, 42 U.S.C. Sections 4950 through 5085. (7-1-98)

3~~0~~1. **Relocation Assistance**. Relocation assistance payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970. (7-1-98)

3~~1~~2. **Disaster Relief**. Disaster relief assistance paid under the Disaster Relief Act of 1974 and aid provided under any federal statute for a President-declared disaster. Comparable disaster assistance provided by states, local governments, and disaster assistance organizations. (7-1-98)

3~~2~~3. **Radiation Exposure Payments**. Payments made to persons under the Radiation Exposure Compensation Act. (7-1-98)

3~~3~~4. **Agent Orange**. Agent Orange settlement payments. (7-1-98)

3~~4~~5. **Spina Bifida**. Spina bifida allowances paid to children of Vietnam veterans. (7-1-99)

3~~5~~6. **Japanese-American Restitution Payments**. Payments by the U.S. Government to Japanese-Americans, their spouses, or parents (or if deceased to their survivors) interned or relocated during World War II. (3-30-01)

3~~6~~7. **Vista Payments**. Volunteers in Service to America (VISTA) payments. (3-30-01)

3~~7~~8. **Subsidized Employment**. Employment for which the employer receives a subsidy from public funds to offset a portion or all of the wages and costs of employing an individual. This type of employment is a short-term placement, pays prevailing wage, and a specific skill is acquired. The employment is prescribed through a memorandum of agreement with no guarantee of permanent employment for the participant. (5-8-09)

3~~8~~9. **Temporary Census Income**. All wages paid by the Census Bureau for temporary employment related to U.S. Census activities are excluded for a time period not to exceed six (6) months during the regularly scheduled ten (10) year U.S. Census. (4-7-11)

~~39~~40. **Income Excluded By Federal Law**. Income excluded by federal law is not counted in determining income available to the participant. (7-1-12)

(BREAK IN CONTINUITY OF SECTIONS)

240. INDIVIDUALS EXCLUDED FROM FAMILY SIZE.
Individuals listed in Subsections 240.01 through 240.0~~5~~6 are excluded from the family size in determining eligibility and grant amount. Income and resources of these ineligible family members are counted unless otherwise excluded in Section 215 of these rules. ~~(7-1-99)~~( )

01. Ineligible Non-Citizens. Individuals who are non-citizens and are not listed in Section 131. (7-1-98)

02. Drug Related Conviction. 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)

03. Fleeing Felons. Felons who are fleeing to avoid prosecution, custody or confinement after conviction of a felony or an attempt to commit a felony. (7-1-98)

04. Felons Violating a Condition of Probation or Parole. Felons who are violating a condition of probation or parole imposed for a federal or state felony. (7-1-98)

05. Fraudulent Misrepresentation of Residency. Individuals convicted in a federal or state court of fraudulently misrepresenting residence to get TANF, AABD, Food Stamps, Medicaid or SSI from two (2) or more states at the same time are ineligible for ten (10) years from the date of conviction. (7-1-99)

06. Children Receiving Supplemental Security Income (SSI). A child who is receiving Supplemental Security Income (SSI). ( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the 2018 legislative session unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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(b), 56-264, and 56-1610, Idaho Code.

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

These rules allow schools that provide Medicaid services to bill for services identified as needed retroactively up to 30 days. 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 2, 2017, Idaho Administrative Bulletin, **Vol. 17-8, pages 32 through 37**.

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 estimates that there will be no general fund impact for the 30-day retroactive billing period for Medicaid reimbursable services for the 2017-18 school year. Schools provide their own matching dollars for these services. The estimated total fiscal impact is $994,000 of which the federal share is $695,500; and the school matching share is $298,500.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Angie Williams at (208) 287-1169.

DATED this 3rd day of November, 2017.

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 PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is August 1, 2017.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections: 56-202(b), 56-264, and 56-1610, 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 16, 2017.

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 Medicaid Advisory Committee and schools held negotiations concerning the issue of schools not being able to receive Medicaid reimbursement for Medicaid services provided between the time the need was identified by the school and the time a recommendation or referral from a physician or practitioner of the healing arts could be obtained. Amendments to these rules will allow schools to bill for services identified as needed retroactively, up to 30 days, once a recommendation or referral for a Medicaid reimbursable service delivered in a school setting is received. This time frame aligns with the Department's therapy rules in Section 733 of this chapter.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule confers a benefit as it provides for the schools to be reimbursed by Medicaid for certain services.

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

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

The Department estimates that there will be no general fund impact for the 30-day retroactive billing period for Medicaid reimbursable services for the 2017-18 school year. Schools provide their own matching dollars for these services. The estimated total fiscal impact is $994,000 of which the federal share is $695,500; and the school matching share is $298,500.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was held by video conference throughout the state and a live meeting in Boise, on May 23, 2017. The Notice of Negotiated Rulemaking published in the May 3, 2017, Idaho Administrative Rules, **Vol. 17-5, page 65**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Angie Williams 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 August 23, 2017.

DATED this 10th day of July, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1701

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. (7-1-16)

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 more than thirty (30) days prior to ~~*receiving a*~~ the 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; (7-1-16)

d. Include recommended interventions to address each need; and (7-1-16)

e. Include name, title, and signature of the person conducting the evaluation. (7-1-16)

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 more than thirty (30) days prior to ~~*receiving a*~~ the 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 of preventing or treating behavioral conditions for students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. (7-1-16)

i. Group services must be provided by one (1) qualified staff providing direct services for a maximum of three (3) students. (7-1-16)

ii. As the number and severity of the students with behavioral issues increases, the staff-to-student ratio must be adjusted accordingly. (7-1-16)

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. Authorized items must be for use at the school where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be for the student's exclusive use and must be transferred with the student if the student changes schools. All equipment purchased by Medicaid belongs to the student. (7-1-16)

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. (7-1-16)

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: (7-1-16)

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 bathroom routines; (7-1-16)

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (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)

v. 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. Community Based Rehabilitation Services (CBRS) Services and Evaluation. Community Based Rehabilitation Services and evaluation services that are interventions to 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, 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. (7-1-16)

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 when: (7-1-16)

i. The student requires special transportation assistance, a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student ~~*and recommended by a physician or other practitioner of the healing arts*~~; ~~*(7-1-16)*~~( )

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 speak or understand 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. (7-1-16)

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 five (5) years: (7-1-16)

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), 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: (7-1-16)

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. (7-1-16)

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, title, and signature of the person providing the service; (7-1-16)

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*~~ within thirty (30) days of 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. ~~*(7-1-16)*~~( )

c. A recommendation or referral must be obtained for the service at least every three hundred sixty-five (365) days. (7-1-16)

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' parent or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. (7-1-16)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must 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 (7-1-16)

b. 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. (7-1-16)

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)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1702

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, and 42 CFR Sections 438, 440, and 457.

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

Under the CFR sections cited above, access to mental healthcare services cannot be more restrictive than access for medical/surgical services. The rule changes in this docket allow the Department flexibility to adjust requirements for authorizations and coverage to ensure that access to mental health services is consistent with the requirements in CFR. Companion Docket No. 16-0310-1702 is also publishing in this bulletin.

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 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 253 through 271**.

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 will have an estimated $121,572 impact to the State General Fund. There will be a federal fund spending authority impact of $300,114 in the Division of Medicaid from matching federal funds through Federal Medical Assistance Percentage (FMAP). This impact is due to removing restrictions for behavioral health care services to comply with federal requirements.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact William Deseron at (208) 364-1967.

DATED this 16th day of November, 2017.

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, and 42 CFR Sections 438, 440, and 457.

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

PUBLIC HEARING

Friday, October 13, 2017 – 2:00 p.m. (Local)

Central Idaho – DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

TELECONFERENCE CALL-IN

Toll Free: 1-877-820-7831
Participant Code: 701700

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

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

Under the CFR sections cited above, access to mental healthcare services cannot be more restrictive than access for medical/surgical services. These rule changes allow the Department flexibility to adjust requirements for authorizations and coverage to ensure that access to mental health services is consistent with the requirements in CFR.

Specifically, inpatient psychiatric stays will be permitted for as long as they are medically necessary, and will be subject to the same reviews as general hospital stays. Participant eligibility for inpatient psychiatric stays are being defined to align with CFR restrictions. General hospital procedural guidelines are being changed to provide a psychiatric services structure with which to align. General hospital inpatient provisions are being changed to match current Medicaid practice and Centers for Medicare and Medicaid Services (CMS) requirements. Finally, under physician services, limitations for psychiatric evaluations and psychotherapy are being removed. Should the Department need to make adjustments to remain in compliance with federal requirements or to maintain appropriate utilization of services in the future, these changes will allow for modification for those needs.

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

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

The fiscal impact associated with this rule change is minimal to none. An analysis conducted by the Division of Medicaid concluded any potential impact is so minimal that requesting additional funds is not warranted at this time.

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 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, pages 36 and 37**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact William Deseron at (208) 364-1967.

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 25, 2017.

DATED this 1st day of September, 2017

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. 16-0309-1702

402. INPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.
The policy, rules, and regulations to be followed will be those cited in 42 CFR 456.50 through 42 CFR 456.145. All hospital services must conform to federal and state laws and regulations. Services must be medically necessary as defined in Section 011 of these rules. ~~(3-30-07)~~( )

01. Initial Length of Stay. Prior authorization requirement for an initial length of stay will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. ( )

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for hospital days in excess of the initial length of stay, or previously approved extended stay. ( )

0~~1~~3. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services: (3-30-07)

a. Payment for accommodations is limited to the hospital's all-inclusive rate. The all-inclusive rate is a flat fee charge incurred on a daily basis that covers both room and board. (3-30-07)

b. The Department must not authorize reimbursement above the all-inclusive rate unless the attending physician orders a room that is not an all-inclusive rate room for the patient because of medical necessity. (3-30-07)

~~***02. Limitation of Administratively Necessary Days (ANDs)**. Each participant is limited to no more than three (3) ANDs per discharge. In the event that a nursing facility level of care is required, an AND may be authorized provided that the hospital documents that no nursing facility bed is available within twenty-five (25) miles of the hospital.* ***(3-30-07)***~~

403. INPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. Some services may require a prior authorization from the Department or its designee. Documentation for the request must include the most recent plan of care and adequate documentation to demonstrate continued medical necessity. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ( )

02. Certification of Need. At the time of admission, the physician must certify that inpatient services are necessary. Recertification must occur at least every sixty (60) days inpatient hospital services are required, but may be required more frequently as determined by the Department. ( )

03. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to a hospital and updated at least every sixty (60) days, but may be required more frequently as determined by the Department. The plan must include: ( )

a. Diagnoses, symptoms, complaints, and complications indicating the need for admission; ( )

b. A description of the functional level of the individual; ( )

c. Any orders for medications, treatments, rehabilitative services, activities, social services, or diet; and ( )

d. Plans for continuing care or discharge, as appropriate. ( )

04. Request for Extended Stay. To qualify for reimbursement, authorization must be obtained from the Department, or its designee. The request should be made before the initial length of stay or previously authorized extended stay ends, and submitted as designated by the Department, or its designee. Documentation for the request should include the most recent plan of care. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ( )

05. Administratively Necessary Day Requests (AND). When Administratively Necessary Days are requested, the hospital must provide the Department with complete and timely documentation prior to the participant's anticipated discharge date ~~*in order to be considered*~~. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing ~~*or by telephone*~~. Hospitals must make the documentation and related information requested by the Department available within ten (10) working days of the date of the request ~~*in order*~~ for subsequent payment to be granted. The documentation provided by the hospital will include, but is not limited to: ~~*(3-30-07)*~~( )

~~*01*~~**a.** A Brief Summary. A brief summary of the participant's medical condition; and (3-30-07)

~~*02*~~**b.** Statements. Statements as to why the participant ~~*cannot receive the necessary medical services in*~~ is unable to discharge to a nonhospital setting; and ~~*(3-30-07)*~~( )

~~*03*~~**c.** Documentation. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization within twenty-five (25) miles which is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact. ~~*(3-30-07)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

405. INPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.
Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of inpatient services in accordance with the procedures detailed under this Section of rule. The upper limits observed by the Department in reimbursing each individual

hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. (3-30-07)

01. Exemption of New Hospitals. A hospital that has operated as the type of facility for which it is certified (or the equivalent thereof) under present and previous ownership for less than three (3) full years will be paid in accordance with the Title XVIII principles of reasonable cost reimbursement, including those provisions applicable to new providers for the carryover and recovery of unreimbursed costs, in accordance with 42 CFR Section 413.64. (3-30-07)

02. Medicaid Inpatient Operating Cost Limits. The following describe the determination of inpatient operating cost limits. (3-30-07)

a. Medicaid Cost Limits for Dates of Service Prior to a Current Year. The reimbursable reasonable costs for services rendered prior to the beginning of the principal year, but included as prior period claims in a subsequent period's cost report, will be subject to the same operating cost limits as the claims under settlement. (3-30-07)

b. Application of the Medicaid Cost Limit. In the determination of a hospital's reasonable costs for inpatient services rendered after the effective date of a principal year, a ~~H~~hospital ~~I~~inflation ~~I~~index, computed for each hospital's fiscal year end, will be applied to the operating costs, excluding capital costs and other allowable costs as defined for the principal year and adjusted on a per diem basis for each subsequent year under the ~~H~~hospital ~~I~~inflation ~~I~~index. ~~(3-30-07)~~( )

i. Each inpatient routine service cost center, as reported in the finalized principal year end Medicare cost report, will be segregated in the Medicaid cost limit calculation and assigned a share of total Medicaid inpatient ancillary costs. The prorated ancillary costs will be determined by the ratio of each Medicaid routine cost center's reported costs to total Medicaid inpatient routine service costs in the principal year. (3-30-07)

ii. Each routine cost center's total Medicaid routine service costs plus the assigned share of Medicaid inpatient ancillary costs of the principal year will be divided by the related Medicaid patient days to identify the total costs per diem in the principal year. (3-30-07)

(1) The related inpatient routine service cost center's per diem capital and graduate medical education costs plus the prorated share of inpatient ancillary capital costs will be subtracted from the per diem amount identified in Subsection 405.02.b.ii. of this rule to identify each inpatient routine service cost center per diem cost limit in the principal year. (3-30-07)

(2) If a provider did not have any Medicaid inpatient utilization or render any Medicaid inpatient services in an individual inpatient routine service cost center in the fiscal year serving as the principal year, the principal year for only those routine cost centers without utilization in the provider's principal year will be appropriately calculated using the information available in the next subsequent year in which Medicaid utilization occurred. (3-30-07)

iii. Each routine cost center's cost per diem for the principal year will be multiplied by the ~~H~~hospital ~~I~~inflation ~~I~~index for each subsequent fiscal year. ~~(3-30-07)~~( )

iv. The sum of the per diem cost limits for the Medicaid inpatient routine service cost centers of a hospital during the principal year, as adjusted by the ~~H~~hospital ~~I~~inflation ~~I~~index, will be the Medicaid cost limit for operating costs in the current year. ~~(3-30-07)~~( )

(1) At the date of final settlement, reimbursement of the Medicaid current year inpatient routine cost centers plus the assigned ancillary costs will be limited to the total per diem operating costs as adjusted for each subsequent fiscal year after the principal year through the current year by the ~~H~~hospital ~~I~~inflation ~~C~~cost ~~I~~index. ~~(3-30-07)~~( )

(2) Providers will be notified of the estimated inflation index periodically or ~~H~~hospital ~~I~~inflation ~~I~~index (CMS Market Basket Index) prior to final settlement only upon written request. ~~(3-30-07)~~( )

03. Adjustments to the Medicaid Cost Limit. A hospital's request for review by the Department concerning an adjustment to or exemption from the cost limits imposed under the provisions set forth in Section 405 of this chapter of rules, must be granted under the following circumstances: (3-30-07)

a. Adjustments. Because of Extraordinary Circumstances. Where a provider's costs exceed the Medicaid limit due to extraordinary circumstances beyond the control of the provider, the provider can request an adjustment to the cost limit to the extent the provider proves such higher costs result from the extraordinary circumstances including, but not limited to, increased costs attributable to strikes, fires, earthquake, flood, or similar, unusual occurrences with substantial cost effects. (3-30-07)

b. Reimbursement to Public Hospitals. A ~~P~~public ~~H~~hospital that provides services free or at a nominal charge, which is less than, or equal to fifty percent (50%) of its total allowable costs, will be reimbursed at the same rate that would be used if the hospital's charges were equal to, or greater than, its costs. ~~(3-30-07)~~( )

c. Adjustment to Cost Limits. A hospital is entitled to a reasonable increase in its Medicaid ~~C~~cost limits if the hospital shows that its per diem costs of providing services have increased due to increases in case- mix, the adoption of new or changed services, the discontinuation of services or decrease in average length of stay for Medicaid inpatients since the principal year. Any hospital making such showing is entitled to an increase commensurate with the increase in per diem costs. ~~(3-30-07)~~( )

i. The Medicaid operating cost limit may be adjusted by multiplying cost limit by the ratio of the current year's ~~C~~case-~~M~~mix ~~I~~index divided by the principal year's ~~C~~case-~~M~~mix ~~I~~index. ~~(3-30-07)~~( )

ii. The contested case procedure set ~~for~~ forth in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings," is available to larger hospitals seeking such adjustments to their Medicaid ~~C~~cost ~~L~~limits. ~~(3-30-07)~~( )

d. Adjustment to the Proration of Ancillary Costs in the principal year. Where the provider asserts that the proration of ancillary costs does not adequately reflect the total Medicaid cost per diem calculated for the inpatient routine service cost centers in the principal year, the provider may submit a detailed analysis of ancillary services provided to each participant for each type of patient day during each participant's stay during the principal year. The provider will be granted this adjustment only once upon appeal for the first cost reporting year that the limits are in effect. (3-30-07)

04. Payment Procedures. The following procedures are applicable to in-patient hospitals: (3-30-07)

a. The participant's admission and length of stay is subject to ~~preadmission~~ prior authorization, concurrent review, continued stay review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. If ~~such~~ a review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 40~~5~~2 of this chapter of rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in S~~ubs~~ection 405~~.05~~ of this rule. ~~(3-30-07)~~( )

i. All admissions are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. (3-30-07)

ii. Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-30-07)

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be

obtained from the participant. (3-30-07)

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or the reasonable cost of semi-private rates for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment which would be determined as reasonable cost using the Title XVIII standards and principles. (3-30-07)

05. Hospital Penalty Schedule. (3-30-07)

a. A request for a preadmission and/or continued stay QIO review that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

b. A request for a preadmission and/or continued stay QIO review that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

c. A request for a preadmission and/or continued stay QIO review that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

d. A request for a preadmission and/or continued stay QIO review that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

e. A request for a preadmission and/or continued stay QIO review that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay. (3-30-07)

06. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/ID rates are excluded from this calculation. (3-30-07)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (3-30-07)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (3-30-07)

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (3-30-07)

07. Reimbursement for Services. Routine services as addressed in Subsection 405.08 of this rule include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

08. Hospital Swing-Bed Reimbursement. The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital ("swing") beds who require nursing facility level of care. (3-30-07)

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: (3-30-07)

i. The Department's Licensure and Certification Section finds the hospital in conformance with the

requirements of 42 CFR 482.58 "Special Requirements" for hospital providers of long-term care services ("swingbeds"); and (3-30-07)

ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and (3-30-07)

iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and (3-30-07)

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and (3-30-07)

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.58(a)(1) for swing-bed purposes; and (3-30-07)

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. (3-30-07)

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: (3-30-07)

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled"; and (3-30-07)

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. (3-30-07)

c. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (3-30-07)

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/ID facilities' rates are excluded from the calculations. (3-30-07)

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (3-30-07)

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (3-30-07)

iv. Routine services include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. (3-30-07)

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. (3-30-07)

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. (3-30-07)

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety five (1,095) days which may be prorated over a shorter fiscal

period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. (3-30-07)

d. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. (3-30-07)

09. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. (3-29-10)

a. DSH Survey Requirements. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. The DSH survey must be returned to the Department on or before May 31 of the same calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. No later than July 15 of each calendar year, the Department must notify each hospital of their calculated DSH payment and notify each hospital of its preliminary calculated distribution amount. A hospital may file an amended survey to complete, correct, or revise the original DSH survey by submitting the amended survey and supporting documentation to the Department no later than thirty (30) days after the notice of the preliminary DSH calculation is mailed to the hospital. The state's annual DSH allotment payment will be made by September 30 of the same calendar year based on the final DSH surveys and Department data. (3-30-07)

b. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals which: (3-30-07)

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. (3-30-07)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (3-29-10)

(1) Subsection 405.09.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (3-30-07)

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. (3-30-07)

iii. The MUR will not be less than one percent (1%). (3-30-07)

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.09.b.ii. and 405.09.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.09.b.vi. through 405.09.b.x. of this rule. (3-29-10)

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or

exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (3-30-07)

c. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho which have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.09.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: (3-29-10)

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (3-30-07)

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (3-30-07)

d. Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (3-30-07)

e. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (3-30-07)

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. (3-30-07)

ii. Claims of uninsured costs which increase the maximum amount which a hospital may receive as a DSH payment must be documented. (3-30-07)

f. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (3-30-07)

g. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (4-7-11)

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (4-7-11)

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (4-7-11)

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (4-7-11)

(1) Recover the overpayment from the provider; and (4-7-11)

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (4-7-11)

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise

required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (4-7-11)

10. Out-of-State Hospitals. (3-30-07)

a. Cost Settlements for Certain Out-of-State Hospitals. Hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: (3-30-07)

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or (3-30-07)

ii. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (3-30-07)

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. (3-30-07)

~~***11. Institutions for Mental Disease (IMD)**. Except for individuals under twenty-two (22) years of age which are contracted with the Department under the authority of the Division of Family and Community Services and certified by the Health Care Financing Administration, no services related to inpatient care will be covered when admitted to a freestanding psychiatric hospital.* (3-30-07)~~

12~~11~~. Audit Function. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (3-30-07)

13~~12~~. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (3-30-07)

14~~13~~. Availability of Records of Hospital Providers. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. (3-30-07)

15~~14~~. Interim Cost Settlements. The Department may initiate or a hospital may request an interim cost settlement based on the Medicare cost report as submitted to the Medicare Intermediary. (3-30-07)

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (3-30-07)

b. Hard Copy of Cost Report. Hospitals which request to undergo interim cost settlement with Idaho Medicaid must submit a hard copy of the Medicare cost report to the Department upon filing with the Intermediary. (3-30-07)

c. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (3-30-07)

1~~6~~5. Notice of Program Reimbursement. Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider which sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (3-30-07)

a. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report from the Medicare Intermediary. (3-30-07)

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-30-07)

1~~7~~6. Nonappealable Items. The formula for the determination of the ~~H~~hospital ~~I~~inflation ~~I~~index, the principles of reimbursement which define allowable cost, non-Medicaid program issues, interim rates which are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits must not be accepted as appealable items.
~~(3-30-07)~~( )

1~~8~~7. Interim Reimbursement Rates. The interim reimbursement rates are reasonable and adequate to meet the necessary costs which must be incurred by economically and efficiently operated providers which provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (3-30-07)

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. The interim rate will reflect the Medicaid Inpatient Operating Cost Limits used to set inpatient rates and the Reimbursement Floor Percentage. (3-30-07)

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (3-30-07)

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. (3-30-07)

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. (3-30-07)

1~~9~~8. Audits. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

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 S~~ubs~~ection 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. Telehealth. Telehealth as defined in Title 54, Chapter 57, Idaho Code. (3-25-16)

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)~~

0~~2~~1. **Sterilization Procedures**. ~~*Particular r*~~Restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. ~~(3-30-07)~~( )

0~~3~~2. **Abortions**. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. (3-30-07)

0~~4~~3. **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 for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. ~~(3-30-07)~~( )

0~~5~~4. **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)

0~~6~~5. **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)

0~~7~~6. **Corneal Transplants and Kidney Transplants**. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. (3-30-07)

0~~8~~7. **Telehealth**. Synchronous interaction telehealth encounters, delivered as defined in Title 54, Chapter 57, Idaho Code, are reimbursable as follows: (3-25-16)

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. (3-25-16)

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. (3-25-16)

(BREAK IN CONTINUITY OF SECTIONS)

~~***700. (RESERVED)***~~

700. INPATIENT BEHAVIORAL HEALTH SERVICES: DEFINITIONS.

01. Freestanding Psychiatric Hospital. A hospital, nursing facility, or other institution of sixteen (16) beds or less that is primarily engaged in the diagnosis and treatment of mental diseases. The hospital is not considered freestanding if it shares a building or campus with another hospital, or is owned by another hospital. ( )

02. Hospital Psychiatric Unit. The psychiatric unit of a general hospital that furnishes inpatient care and treatment services for mental illness under a psychiatrist or other physician qualified to treat mental diseases. ( )

03. Institutions for Mental Disease (IMD). A hospital, nursing facility or other institution of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. A specific licensure is not necessary to meet this definition. This definition does not apply to ICF/IDs. ( )

04. Substance Use Disorder. A substance use disorder is evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance and the current DSM. ( )

701. INPATIENT ~~*PSYCHIATRIC HOSPITAL*~~ BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

01. Inpatient Psychiatric Hospital Services. Participants ~~*must*~~ are eligible who have a ~~*DSM-5*~~ diagnosis from the current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in: ~~*(3-30-07)*~~( )

a. A freestanding psychiatric hospital; ( )

b. A hospital psychiatric unit; ( )

c. Institutions for mental disease for participants meeting the conditions in Subsections 701.01.c.i. and 701.01.c.ii. of this rule: ( )

i. Participants must be under the age of twenty-one (21); and ( )

ii. If a participant reaches age twenty-one (21) while receiving services, he may continue inpatient treatment until services are no longer required, or he reaches age twenty-two (22), whichever comes first. ( )

02. Inpatient Substance Use Disorder Services. Participants are eligible when medical necessity is demonstrated by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Services may be provided in: ( )

a. A freestanding psychiatric hospital; or ( )

b. A hospital psychiatric unit. ( )

0~~1~~3. ~~*Medical Necessity Criteria*~~ Severity of Illness Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. ~~*(3-30-07)*~~( )

a. Severity of illness criteria. The ~~*child*~~ participant must meet one (1) of the following criteria related to the severity of his psychiatric illness: ~~*(3-30-07)*~~( )

i. Is currently dangerous to self as indicated by at least one (1) of the following: (3-30-07)

(1) Has actually made an attempt to take his own life in the last seventy-two (72) hours (details of the attempt must be documented); or (3-30-07)

(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or (3-30-07)

(3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the ~~child~~ participant or a reliable source and details of the ~~child~~ participant's plan must be documented); or ~~(3-30-07)~~( )

(4) ~~A mental health professional has information from the child or a reliable source that the child~~ The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk ~~to~~ of making an attempt ~~to carry out the plan~~ without immediate intervention ~~(details must be documented)~~; or ~~(3-30-07)~~( )

ii. ~~Child~~ Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms which indicate he is a probable danger to others as indicated by one (1) of the following: ~~(3-30-07)~~( )

(1) The ~~child~~ participant has ~~actually~~ engaged in, or threatened behavior harmful or potentially harmful to others or caused serious damage to property which would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or ~~(3-30-07)~~( )

(2) The ~~child~~ participant has made threats to kill or seriously injure others or to cause serious damage to property which would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or ~~(3-30-07)~~( )

(3) A mental health professional has information from the ~~child~~ participant or a reliable source that the ~~child~~ participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or ~~(3-30-07)~~( )

iii. ~~Child~~ Participant is gravely impaired as indicated by at least one (1) of the following criteria: ~~(3-30-07)~~( )

(1) The ~~child~~ participant has such limited functioning that his physical safety and well being are in jeopardy due to his inability for basic self-care, judgment and decision making (details of the functional limitations must be documented); or ~~(3-30-07)~~( )

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the ~~child~~ participant unmanageable and unable to cooperate in non-hospital treatment (details of the ~~child~~ participant's behaviors must be documented); or ~~(3-30-07)~~( )

(3) There is a need for treatment, evaluation, or complex diagnostic testing where the ~~child~~ participant's level of functioning or communication precludes assessment and/or treatment in a non-hospital based setting, and may require close supervision of medication or behavior or both. ~~(3-30-07)~~( )

(4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. ( )

~~b~~04. **Intensity of Service Criteria**. The ~~child~~ participant must meet all of the following criteria related to the intensity of services needed ~~to~~ for treatment ~~his mental illness:~~. ~~(3-30-07)~~( )

~~i. It is documented by the Regional Mental Health Authority that less restrictive services in the community do not exist or do not meet the treatment or diagnostic needs of the child, or the child has been unresponsive to treatment at a less intensive level of care. The services considered, tried, and/or needed must be~~

~~documented; and~~ ~~(3-30-07)~~

a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and ( )

~~ii~~**b.** The services provided ~~in the hospital~~ can reasonably be expected to improve the ~~child~~ participant's condition or prevent further regression so that inpatient services will no longer be needed; and ~~(3-30-07)~~( )

~~iii~~**c.** Treatment of the ~~child~~ participant's ~~psychiatric~~ condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation~~, under the direction of a psychiatrist. The child requiring this treatment must not be eligible for independent passes or unit passes without observation or being accompanied by hospital personnel or a responsible other~~. ~~(3-30-07)~~( )

~~e~~**d.** Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the ~~child~~ participant is in his current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. ~~(3-30-07)~~( )

0~~2~~5. **Exclusions**. If a ~~child~~ participant meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: ~~(3-30-07)~~( )

a. The ~~child~~ participant is unable to actively participate in an outpatient ~~psychiatric~~ treatment program solely because of a major medical condition, surgical illness or injury; or ~~(3-30-07)~~( )

~~**b.** The child demonstrates anti-social or criminal behavior or has criminal or legal charges against him and does not meet the severity of illness or intensity of service criteria; or (3-30-07)~~

~~**c.** The child has anti-social behaviors or conduct problems that are a danger to others but are not attributable to a mental illness (DSM-5) with substantial impairment in thought, mood or perception; or (3-30-07)~~

~~d~~**b.** The ~~child~~ participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability~~; or~~. ~~(3-30-07)~~( )

~~**e.** The child lacks a place to live and/or family supports and does not meet severity of illness and intensity of service criteria; or (3-30-07)~~

~~**f.** The child has been suspended or expelled from school and does not meet severity of illness and intensity of service criteria. (3-30-07)~~

702. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

~~01. Emergency Admissions. An emergency for purposes of a waiver of the prior authorization requirement is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person. A court-ordered admission or physician's emergency certificate does not, in itself, justify characterizing the admission as an emergency admission. The severity of illness and intensity of services criteria must be met. The hospital medical record of the admission must include documentation to support that the participant's status upon admission meets the definition of an emergency, as defined in Section 702 of this chapter of rules. The information for authorization of services must be FAXED, or otherwise delivered to the Department on the next business day following the emergency admission. Requests for authorization of emergency admissions must include the same information as required for elective admissions. (3-30-07)~~

01. Initial Length of Stay. A*n initial length of stay, or a* prior authorization requirement, will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will *never* be more restrictive than requirements for non-behavioral health services in a general hospital. *( )*

02. ~~Length of~~ Extended Stay. ~~An initial length of stay will be established by the Department. An initial length of stay will usually be for no longer than five (5) days. For first time admissions where intensity of services criteria is not met the initial length of stay may not exceed forty-eight (48) hours. A hospital may request a continued stay review from t~~The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for ~~hospital~~ inpatient days in excess of the ~~originally approved number. The continued stay review request may be made no later than the date authorized by the Department. Approval of additional days will be based on the following criteria:~~ initial length of stay or previously approved extended stay. ~~(3-30-07)~~( )

~~**a.** Documentation sufficient to demonstrate the medical necessity criteria is still met; (3-30-07)~~

~~**b.** A plan of care that includes documentation sufficient to demonstrate that the child's psychiatric condition continues to require services which can only be provided on an in-patient basis, including twenty four (24) hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental diseases; and (3-30-07)~~

~~**c.** Documentation sufficient to demonstrate the need for continued hospitalization, and that additional days at in-patient level of care will improve the participant's condition. (3-30-07)~~

03. Excluded Services ~~Limited~~. ~~Inpatient psychiatric hospital services are limited to ten (10) days per year~~ Placement in an IMD for participants between the ages of twenty-one (21) and sixty-four (64) is not a covered service. ~~(3-30-07)~~( )

703. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.
~~Admissions must be authorized by the Department.~~ ~~(3-30-07)~~

01. Prior Authorization ~~for Elective Admissions~~. ~~To qualify for reimbursement, prior authorization must be obtained from the Department prior to an elective admission. An elective admission is defined as one that is planned and scheduled in advance, and is not emergency in nature, as "emergency" is defined in Subsection 702.01 of these rules~~ Some services may require a prior authorization from the Department, or its designee. The Department will set documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. Requests for prior authorization must include: ~~(3-30-07)~~( )

a. Diagnosis; and (3-30-07)

b. Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and (3-30-07)

c. Medical history; and (3-30-07)

d. Mental and physical functional capacity; and (3-30-07)

e. Prognosis~~; and~~. ~~(3-30-07)~~( )

~~**f.** Recommendation by a physician for admission, preferably the primary care physician. If the child is enrolled in the Healthy Connection (HC) program, a HC referral is required. (3-30-07)~~

02. Individual Plan of Care – Content. The individual plan of care is a written plan developed for the participant upon admission. ~~to an in-patient psychiatric hospital~~ The objective of the plan is to improve his condition to the extent that acute psychiatric care is no longer necessary. It must be developed by an interdisciplinary team as defined in Subsection 703.03 of this rule. The plan of care must be ~~developed and~~ implemented within seventy-two (72) hours of admission, and reviewed at least every three (3) days. ~~and must~~ The individual plan of care must contain: ~~(3-30-07)~~( )

a. ~~Be based on a~~ A diagnostic evaluation that includes examination of the medical, behavioral, and

developmental aspects of the participant's situation and reflects the ~~need (~~medical necessity ~~criteria)~~ for in-patient care; and ~~(3-30-07)~~( )

b. Treatment objectives related to conditions that necessitated the admission; and ( )

c. An integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the participant), and experiences designed to meet the objectives; and ( )

d. A discharge plan designed to achieve the participant's discharge at the earliest possible time that includes plans for coordination of community services to ensure continuity of care with the participant's family, school, and community upon discharge. ( )

~~b~~**03. Individual Plan of Care – Interdisciplinary Team**. ~~Be~~ The individual plan of care must be developed by an interdisciplinary team capable of assessing the ~~child~~ participant's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the ~~child~~ participant's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum: ~~(3-30-07)~~( )

a. One of the following: ( )

i. A ~~B~~board-certified psychiatrist ~~(preferably with a specialty in child psychiatry)~~; or ~~(3-30-07)~~( )

ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or (3-30-07)

iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor; and (3-30-07)

b. One of the following: ( )

i~~v~~. ~~Either a~~ A licensed, clinical or master's social worker ~~or a registered nurse with specialized training or one (1) year's experience in treating mentally ill individuals (preferably children)~~; or ~~(3-30-07)~~( )

ii. A registered nurse with specialized training or one (1) year's experience in treating individuals with behavioral health needs; or ( )

~~v~~iii. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating ~~mentally ill~~ individuals ~~(preferably children); and~~ with behavioral health needs, ~~(3-30-07)~~( )

~~vi~~**c.** The participant and his parents, legal guardians, or others into whose care he will be released after discharge. (3-30-07)

~~**c.** State treatment objectives (related to conditions that necessitated the admission); and (3-30-07)~~

~~**d.** Prescribe an integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the child), and experiences designed to meet the objectives; and (3-30-07)~~

~~**e.** Include a discharge and post discharge plan designed to achieve the child's discharge at the earliest possible time and include plans for coordination of community services to ensure continuity of care with the participant's family, school and community upon discharge. (3-30-07)~~

704. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Qualifications. Inpatient hospital psychiatric services ~~for individuals under age twenty-one (21)~~ must be provided under the direction of a physician in a facility accredited by the Joint Commission on

Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which they provide services. ~~*Facilities currently providing psychiatric hospital services under the authority of Family and Community Services that are certified by the Health Care Financing Administration have until October 1, 1998 to comply with this requirement.*~~ To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services ~~*to children*~~. General hospitals licensed to provide services in ~~*Idaho which*~~ *their state,* but are not JCAHO certified, may not bill for psychiatric services beyond emergency screening and stabilization. ~~*(3-30-07)*~~( )

02. Record Keeping. A written report of each evaluation and the plan of care must be entered into the ~~*child*~~ participant's record at the time of admission or if the ~~*child*~~ participant is already in the facility, immediately upon completion of the evaluation or plan. ~~*(3-30-07)*~~( )

03. Utilization Review (UR). The facility must have in effect a written utilization review plan that provides for review of each ~~*child*~~ participant's need for the services that the hospital furnishes him. The UR plan must meet the requirements under 42 CFR 456.201 through 456.245. ~~*(3-30-07)*~~( )

705. INPATIENT ~~*PSYCHIATRIC HOSPITAL*~~ BEHAVIORAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.
Failure to request a ~~*preadmission*~~ prior authorization, concurrent review, or continued stay review in a timely manner will result in a retrospective review being conducted by the Department. If the retrospective review determines the ~~*admission*~~ stay is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 705.02 of this rule. The ~~*primary care*~~ admitting physician will be assessed a penalty for failure to request a ~~*preadmission*~~ prior authorization, concurrent review, or continued stay review in a timely manner as specified in Subsection 705.03 of this rule. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant is not subject to this penalty. ~~*(3-30-07)*~~( )

01. Payment. Reimbursement for the participant's admission and length of stay is subject to ~~*preadmission*~~ prior authorization, concurrent review, continued stay review, or retrospective review by the Department. The hospital and the participant's physician are responsible for obtaining the required review. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. ~~*(3-30-07)*~~( )

a. In reimbursing for inpatient hospital psychiatric services the Department will pay the lesser of customary charges or the reasonable cost of semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-30-07)

b. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. (3-30-07)

~~***c.*** *The participant may be charged for services only when he or she has made an informed decision to incur expenses for services deemed not medically necessary by the Department.* ***(3-30-07)***~~

02. Hospital Penalty Schedule. Failure to request a ~~*preadmission*~~ prior authorization, concurrent review, or continued stay review from the Department in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission~~:~~. ~~*(3-30-07)*~~( )

a. A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars ($260). (3-30-07)

b. A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars ($520). (3-30-07)

c. A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars ($780). (3-30-07)

d. A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars ($1,040). (3-30-07)

e. A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars ($1,300). (3-30-07)

03. Physician Penalty Schedule. Failure to request a preadmission review from the Department in a timely manner will result in the ~~*primary care*~~ admitting physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant. The penalty will be assessed after payment for physician services for a medically necessary hospital admission: ~~*(3-30-07)*~~( )

a. A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars ($50). (3-30-07)

b. A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars ($100). (3-30-07)

c. A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars ($150). (3-30-07)

d. A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars ($200). (3-30-07)

e. A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars ($250). (3-30-07)

706. INPATIENT ~~*PSYCHIATRIC HOSPITAL*~~ BEHAVIORAL HEALTH SERVICES: QUALITY ASSURANCE.
The policy, rules, and regulations to be followed must be those cited in 42 CFR 456.480 through 42 CFR 456.482.
~~*(3-30-07)*~~( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1703

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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, 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:

The Department's Infant Toddler and Medicaid programs are both required by federal law (Section 1905(a) of the Social Security Act) to provide access and reimbursement for early intervention services. Early intervention service requirements are being removed from IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and added as a new Section in this chapter. The rule text is being updated to support program eligibility, service coverage, limitations, provider, and reimbursement requirements. These changes will allow the Department more flexibility for collaboration within IDHW Divisions and ensure all Medicaid-eligible infants and toddlers receive the right preventive services, at the right time, through the best financial means for the State. Updates to references or other minor technical corrections are being made as needed. Companion Docket No. 16-0310-1703 is publishing in this bulletin.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 272-279**.

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 proposed change impacts the Division of Medicaid and the Division of Family and Community Services. Currently both divisions support these services for children with special healthcare needs ages 0-3 through a combination of a federal grant and Medicaid benefits payments.

This rule will enable additional Medicaid coverage for these services, which will allow leveraging federal funds to support better services for Idaho. There is no overall impact to the general fund; however, a transfer of general funds between divisions will be necessary. In addition, the FACS division will require an increase of $1,129,800 in federal spending authority and will revert $1,126,700 in receipt spending authority.

The net impact will increase federal expenditures for these services but will not increase the general fund needs. This will allow us to increase services to children and use state general funds more efficiently.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cindy Brock at (208) 364-1983.

DATED this 16th day of November, 2017.

Tamara Prisock, DHW – Administrative Rules Unit
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: **dhwrules@dhw.idaho.gov**

450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036

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

PUBLIC HEARING

Tuesday, October 17, 2017 – 2:00 p.m. (Local)

Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

TELECONFERENCE CALL-IN

Toll Free: 1-877-820-7831
Participant Code: 626553

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

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

The Department's Infant Toddler and Medicaid programs are both required by federal law to provide access and reimbursement for early intervention services. This rule change streamlines the processes between two Department Divisions and resolves the current access issue. Currently, the Infant Toddler Program has a waiting list of children, including Medicaid-eligible children, that are unable to access Part C, early intervention treatment services. The changes in this docket will keep the State in compliance in both areas, provide a more streamlined approach between the two Divisions, and will ensure improved access to these services for participants.

Specifically, early intervention service requirements are being removed from IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits" and added as a new Section in this chapter. The rule text is being updated to support program eligibility, service coverage, limitations, provider, and reimbursement requirements. These changes will allow the Department more flexibility for collaboration within IDHW Divisions and ensure all Medicaid-eligible infants and toddlers receive the right preventive services, at the right time, through the best financial means for the State. Updates to references or other minor technical corrections are being made as needed.

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

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

This proposed change impacts the Division of Medicaid and the Division of Family and Community Services. Currently both divisions support these services for children with special healthcare needs from birth through the end of their 36th month of age through a combination of a federal grant and Medicaid benefits payments.

This rule will enable additional Medicaid coverage for these services, which will allow leveraging federal funds to support better services for Idaho. There is no overall impact to the general fund; however, a transfer of general funds between divisions will be necessary. In addition, the FACS division will require an increase of $1,129,800 in federal spending authority and will revert $1,126,700 in receipt spending authority.

The net impact will increase federal expenditures for these services but will not increase the general fund needs. This will allow us to increase services to children and use state general funds more efficiently.

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 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, page 38**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1703

011. DEFINITIONS: I THROUGH O.
For the purposes of these rules, the following terms are used as defined below: (3-30-07)

01. ICF/ID. Intermediate Care Facility for People with Intellectual Disabilities. An ICF/ID is an entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-30-07)

02. Idaho Behavioral Health Plan (IBHP). The Idaho Behavioral Health Plan is a prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment as well as case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. (3-20-14)

03. Idaho Infant Toddler Program. The Idaho Infant Toddler Program serves children from birth ~~*up to three (3) years of age (*~~through the end of their 36th month~~*s), and must*~~ of age, who 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*~~. *(7-1-13)*( )

~~***a.*** *These requirements for the Idaho Infant Toddler Program include:* *(7-1-13)*~~

~~i. Adherence to procedural safeguards and time lines; (7-1-13)~~

~~ii. Use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs); (7-1-13)~~

~~iii. Provision of early intervention services in the natural environment; (7-1-13)~~

~~iv. Transition planning; and (7-1-13)~~

~~v. Program enrollment and reporting requirements. (7-1-13)~~

~~b. The Idaho Infant Toddler Program may provide the following services for Medicaid reimbursement: (7-1-13)~~

~~i. Occupational therapy; (7-1-13)~~

~~ii. Physical therapy; (7-1-13)~~

~~iii. Speech-language pathology; (7-1-13)~~

~~iv. Audiology; and (7-1-13)~~

~~v. Children's developmental disabilities services defined under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-13)~~

04. In-Patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-30-07)

05. Intermediary. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-30-07)

06. Intermediate Care Facility Services. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. (3-30-07)

07. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-30-07)

08. Legend Drug. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-30-07)

09. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-30-07)

10. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-30-07)

11. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-30-07)

12. Locum Tenens/Reciprocal Billing. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-30-07)

13. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

14. Medicaid. Idaho's Medical Assistance Program. (3-30-07)

15. Medicaid-Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. (3-30-07)

16. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-30-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-30-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. (3-30-07)

c. Medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-30-07)

17. Medical Supplies. Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)

18. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual (CMS/Medicare DME Coverage Manual). A publication that is incorporated by reference in Section 004 of these rules and contains information on DME supplier enrollment, documentation, claim submission, coverage, appeals, and overpayments. (7-1-17)

19. Midwife. An individual qualified as one of the following: (3-29-12)

a. Licensed Midwife. A person who is licensed by the Idaho Board of Midwifery under Title 54, Chapter 55, Idaho Code, and IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." (3-29-12)

b. Nurse Midwife (NM). An advanced practice registered nurse who is licensed by the Idaho Board of Nursing and who meets all the applicable requirements to practice as a nurse midwife under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-29-12)

20. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-30-07)

21. Nonambulatory. Unable to walk without assistance. (3-30-07)

22. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-30-07)

23. Non-Physician Practitioner. A non-physician practitioner, previously referred to as a midlevel practitioner, comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), and physician assistants (PA), as defined in Sections 010, 011, 012 of these rules. (7-1-17)

24. Nurse Practitioner (NP). A registered nurse or licensed professional nurse (RN) who meets all the

applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-13)

25. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-30-07)

26. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (3-30-07)

27. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-30-07)

28. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-30-07)

29. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in any setting in which normal life activities take place. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (7-1-17)

(BREAK IN CONTINUITY OF SECTIONS)

585. EARLY INTERVENTION SERVICES.
Early Intervention Services for infants and toddlers enrolled in Idaho Medicaid are provided by the Idaho Infant Toddler Program (ITP). Early Intervention Services must be provided in accordance with the Individuals with Disabilities Education Act (IDEA), Part C, and all Medicaid regulations. ( )

586. EARLY INTERVENTION SERVICES: PROGRAM REQUIREMENTS.
Idaho Medicaid and the ITP coordinate the delivery of Early Intervention Services through an intra-agency agreement published on the Department's website. Program requirements include: ( )

01. Physician Recommendation. The ITP can bill for health-related services provided to eligible children when the services are documented as medically necessary and provided under the recommendation of a physician. ITP may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated physician recommendation. The recommendation is valid for up to three hundred sixty-five (365) days. ( )

02. Individualized Family Service Plan (IFSP). The ITP may bill for Medicaid services covered by a current IFSP. The plan must be developed by a multi-disciplinary team and be based on the results of assessment(s). ( )

03. Qualified Staff. ITP staff qualifications must meet IDEA Part C requirements, and all Medicaid regulations as specified in the intra-agency agreement. ( )

587. EARLY INTERVENTION SERVICES: PROVIDER REIMBURSEMENT.
Medicaid will reimburse the Infant Toddler Program for covered medically necessary services. ( )

01. Fee Schedule. Reimbursement for Early Intervention Services will be based on the Idaho Medicaid Fee Schedule for Early Intervention. ( )

02. Payment Review. Reimbursement is subject to pre-payment and post-payment review in accordance with Section 56-209h(3), Idaho Code, and recoupment in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

585~~5~~8. -- 589. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

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. Therapy services provided by a home health agency under a home health plan of care must meet the requirements found in Sections 730 through 739 of these rules, and the requirements found in Sections 720 through 729 of these rules. ~~*(7-1-17)*~~( )

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. (7-1-16)

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. (7-1-16)

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. (7-1-16)

b. Services that address developmentally acceptable error patterns. (4-2-08)

c. Services that do not require the skills of a therapy professional. (7-1-16)

d. Massage, work hardening, and conditioning. (4-2-08)

e. Services that are not medically necessary, as defined in Section 011 of these rules. (4-2-08)

f. Duplicate services, as defined under Section 730 of these rules. (4-2-08)

g. 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). (7-1-16)

i. Biofeedback, unless provided to treat urinary incontinence. (7-1-16)

j. Duplicate Services. (7-1-16)

k. Services that are considered to be experimental or investigational. (7-1-16)

l. Vocational Program. (7-1-16)

m. Vision Therapy. (7-1-16)

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 upon request of the Department. (7-1-17)

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 upon request of the Department. (7-1-17)

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. (7-1-16)

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. (7-1-16)

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. (7-1-16)

(BREAK IN CONTINUITY OF SECTIONS)

735. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment for Therapy Services. The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. (4-2-08)

02. Payment Procedures. Payment procedures are as follows: (3-30-07)

a. Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, "Rules for Home Health Agencies." (4-2-08)

b. Therapists enrolled with Medicaid as independent practitioners and licensed by the appropriate state licensing board will be reimbursed on a fee-for-service basis. Only those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. The maximum fee will be based upon the Department's fee schedule, available from the central office for the Division of Medicaid, the contact information for which is found in Section 005 of these rules. (3-20-14)

c. Therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (4-2-08)

d. Payment for therapy services rendered to participants in long-term care facilities is included in the facility reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-13)

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. (4-2-08)

~~***f.*** *Payment for therapy services rendered by the Idaho Infant Toddler Program will be reimbursed on a fee for service basis.* *(7-1-13)*~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1704

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Under a court-approved settlement agreement, the Department will use a new assessment tool to replace the SIB-R assessment tool. The Department uses assessment tools to determine developmental disability eligibility, waiver eligibility, skill level, and the participant's budget for services. Reference to the SIB-R assessment tool is being removed from this chapter.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 280-281**.

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

The fiscal impact to implement and use a new assessment tool is a total of $909,375. These costs are funded by 71.26% ($648,020) federal funds and 28.74% ($261,355) state general funds. The costs to the state are included in the SFY 2018 budget previously approved by the 2017 Legislature.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Karen Westbrook at (208) 364-1960.

DATED this 3rd day of November, 2017.

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

PUBLIC HEARING

Monday, October 23, 2017 – 3:00 p.m. (MDT)

Medicaid Central Office
3232 Elder Street
Conference Room D - West/East
Boise, ID 83705

TELECONFERENCE CALL-IN

Toll Free: 1-877-820-7831
Participant Code: 301388

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

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

Under a court-approved settlement agreement, the Department is implementing the use of a new assessment tool to replace the SIB-R assessment tool. The Department uses assessment tools to determine developmental disability eligibility, waiver eligibility, skill level, and the participant's budget for services. Reference to the SIB-R assessment tool is being removed from this chapter.

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

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

The fiscal impact to implement and use a new assessment tool is a total of $909,375. These costs are funded by 71.26% ($648,020) federal funds and 28.74% ($261,355) state general funds. The costs to the state were included in the SFY 2018 budget previously approved by the 2017 Legislature.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking because the change is being made to comply with a court-approved settlement agreement.

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 SIB-R Comprehensive Manual is being deleted from the documents that are incorporated by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Karen Westbrook at (208) 364-1960.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-1704

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (3-30-07)

01. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the "Under the Direction of" Rule technical report is available on the internet at: http://www.asha.org/policy/ps2004-00098.htm. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. (3-29-10)

02. DSM-5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Arlington, VA, American Psychiatric Association, 2013. A copy of the manual is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. (3-20-14)

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-30-07)

04. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual 2016, As Amended (CMS/Medicare DME Coverage Manual). Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the CMS/Medicare DME Coverage Manual is available via the Internet at https://med.noridianmedicare.com/web/jddme/education/supplier-manual. (7-1-17)

05. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-30-07)

~~***06. SIB-R Comprehensive Manual**. Scales of Independent Behavior – Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. A copy is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho 83702. (3-30-07)~~

0~~7~~6. **Travel Policies and Procedures of the Idaho State Board of Examiners**. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov. (3-30-07)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the amendment to the temporary rule is September 1, 2017. This pending rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a pending rule and amended a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code.

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

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

Providers have complained about the difficulties they have entering the market due to the rate methodology related to starting a Behavioral Care Unit. A change in the rules is needed to facilitate increasing the number of Behavioral Care Unit facilities in Idaho and thereby improve access to behavioral health care.

Currently, a provider must self-fund the first year of operations in order to generate a full year of cost reporting. After the initial year, reimbursement for providing services as a Behavioral Care Unit can commence. These rule changes will shorten the cost reporting period from a full year to a minimum of sixty (60) calendar days. The expedited reimbursement will allow more providers to enter the market and reduce access issues throughout the state.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code, and is being republished following this notice. Rather than keep the temporary rule as previously adopted while the pending rule awaits legislative approval, the Department amended the temporary rule with the same revisions made to the pending rule.

Only the sections that differ from the proposed rule text are printed in this Bulletin. The original text of the temporary and proposed rule was published in the August 2, 2017, Idaho Administrative Bulletin, **Vol. 17-8, pages 38 through 41**.

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

There is no fiscal impact to the General Fund or dedicated funds. While more providers would enter the market, and receive reimbursement more rapidly, the Department will save money as a result of fewer patients staying in hospitals due to increased access to Behavioral Care Units.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule and the amendment to temporary rule, contact KayLee Leavitt at (208) 287-1175.

DATED this 3rd day of November, 2017.

Tamara Prisock, DHW – Administrative Rules Unit
Phone: (208) 334-5500 / Fax: (208) 334-6558
E-mail: **dhwrules@dhw.idaho.gov**

450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2017.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections: 56-202(b), 56-264, and 56-1610, Idaho Code.

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

PUBLIC HEARING
Tuesday, August 22, 2017 – 1:00 pm (Local)

Central Idaho – DHW Office
3232 Elder Street
Conference Room D – East
Boise, ID 83705

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Providers have expressed their concerns about the difficulties they have entering the market due to the rate methodology related to starting a Behavioral Care Unit. A rule change is needed to facilitate increasing the number of Behavioral Care Unit facilities in Idaho and improving access to behavioral health care.

Currently, a provider must self-fund the first year of operations in order to generate a full year of cost reporting. After the initial year, reimbursement for providing services as a Behavioral Care Unit can commence. These rule changes will shorten the cost reporting period from a full year to a minimum of sixty (60) calendar days. The expedited reimbursement will allow more providers to enter the market and reduce access issues throughout the state.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that this temporary adoption of rule confers a benefit as it will make it easier for providers who wish to start up Behavioral Care Units to enter the market.

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

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

There is no fiscal impact to the General Fund or dedicated funds. While more providers would enter the market, and receive reimbursement more rapidly, the Department will save money as a result of fewer patients staying in hospitals due to increased access to Behavioral Care Units.

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 3, 2017, Idaho Administrative Bulletin, **Vol. 17-5, page 66**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact KayLee Leavitt at (208) 287-1175.

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 23, 2017.

DATED this 10th day of July, 2017.

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. 16-0310-1701

267. NURSING FACILITY: TREATMENT OF NEWLY LICENSED FACILITIES WITH BEHAVIORAL CARE UNITS ~~*(BCU)*~~.

01. Criteria to Qualify as a New BCU *On or After September 1, 2017*. ~~*A nursing facility provider must meet the following criteria to qualify as a new BCU nursing facility provider:*~~ Facilities licensed *on or after* September 1, 2017, must meet the qualifications for a BCU described in Subsections 266.02, 266.03, and 266.05 through 266.15 of these rules. BCU facilities existing prior to this date that receive a new license due to a change in ownership will not be subject to the provisions of this rule. ~~*(4-4-13)*~~*( )*

~~***a.*** *BCU days from the cost report period, regardless of payer source, are divided by the total occupied days in the nursing facility, and that calculation must equal or exceed a minimum of twenty percent (20%).* *(4-4-13)*~~

~~***b.*** *A qualifying cost report must demonstrate that the nursing facility provider has a qualifying program in place with residents.* *(4-4-13)*~~

~~***02. First Cost Reporting Year.*** *No BCU eligibility, or increased direct care cost limit will be allowed in the first cost reporting year the BCU program is added.* *(4-4-13)*~~

~~***03. Qualifying Report in Tandem with BCU Eligibility.*** *Once a qualifying cost report is submitted for the BCU program, and the nursing facility provider qualifies in tandem with the BCU eligibility criteria, the cost report will be used to set a prospective rate effective the following July 1 rate period with the increased direct care cost limit.* *(4-4-13)*~~

02. Reimbursement for Years One (1) Through Three (3). Beginning with the first day of the first month following approval of the BCU license and when the provider can demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty-day (60) period, equals or exceeds a minimum of twenty percent (20%), the provider's rate will change to reflect BCU services. The provider will be reimbursed at the median rate for BCU facilities of that type, either freestanding or hospital-based, for the remaining period within the first three (3) full years of operation. If there are no facilities of the same type (for example, no other hospital-based BCUs), the provider will receive the median rate for their type, but

the direct *cost* portion of the rate will be revised to the median rate of existing BCUs. The rate change to reflect BCU services will not be retroactive to rate quarters paid prior to meeting the twenty percent (20%) BCU occupancy requirement. ( )

a. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Subsection 266.07 of these rules. If the provider did not meet the BCU qualifications described in Section 266 of these rules, with the exception of Subsections 266.01 and 266.04, for a full cost report year corresponding to the initial application year, the twenty percent (20%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year. ( )

b. During the period of limitation, the facility's rate will be modified annually on July 1st to reflect the current median rate for skilled care facilities of that type. After the first three (3) complete years of operations, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Subsections 266.03 and 266.05 of these rules. ( )

c. During the period of limitation, providers must demonstrate annually that BCU days were equal to or exceeded twenty percent (20%), as described in Subsection 267.02 of this rule. Providers must provide a report to the Department with a calculation of BCU days for each month during the period being reviewed. If the twelve-month (12) average falls below twenty percent (20%), then the BCU reimbursement will revert back to the median rate per Section 260 of these rules. Once the Department has established the provider has met the requirements of Subsection 267.01 of this rule they will be eligible for a new rate outlined in Subsection 267.02.b. of this rule. ( )

268. NURSING FACILITY: EXISTING PROVIDER ELECTS TO ADD BEHAVIORAL CARE UNIT (BCU).

An existing nursing facility provider that elects to add a BCU on or after ~~*July 1, 2011*~~ September 1, 2017, may be deemed eligible after meeting the following requirements: ~~*(4-4-13)*~~( )

~~***01. Qualifying Cost Report**. A qualifying cost report that demonstrates a qualifying program is in place with residents and meets the criteria in Section 282 of these rules.* *(4-4-13)***~~

0~~2~~1. **Meet Criteria for BCU**. The nursing facility provider must meet the criteria for a BCU described in Section 266 of these rules. (4-4-13)

02. BCU Eligible Days. The provider must demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty (60) day period, equals or exceeds a minimum of twenty percent (20%). ( )

03. BCU Payments. ~~*No BCU payments or increased direct care cost limits will be allowed in the first cost reporting year the program is added. Once a qualifying cost report is submitted, and the provider qualifies in tandem with the BCU criteria, the cost report will be used to set a prospective rate, effective with the following July 1 rate period with the increased direct care cost limit.*~~ Once the provider has met the requirements of Subsections 268.01 and 268.02 of this rule, beginning with the first day of the first quarter following approval of the BCU license, the provider's rate will change to reflect BCU services. At no time will the rate be adjusted mid-quarter. The rate will be calculated as follows. ~~*(4-4-13)*~~( )

a. The indirect costs, costs exempt from limitations, and property cost will be reimbursed in the same manner as all other *nursing facilities* in accordance with reimbursement provisions contained in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

b. The direct cost portion of the rate will be reimbursed as a prospective rate not subject to a change from an interim rate to a final rate. The direct *cost* portion of the rate will be calculated by determining the median direct *cost portion* for BCU facilities of that type (freestanding or hospital-based) effective on July 1 of the rate year. If there are no facilities of the same type (for example no other hospital-based BCUs), the direct *cost* portion of the rate will be set at the median rate of existing BCUs. The direct *cost* portion of the rate will be updated on July 1 of each rate year until the provider has a qualifying twelve-month (12) cost report, as described in Subsection 268.03.d. of this rule. ( )

c. The provider's total calculated rate will be subject to customary charge limitations and any other rate reductions implemented for other providers. ( )

d. Once the provider has a twelve-month (12) cost report that contains a full year of BCU costs, their rate will be calculated in the same manner as other providers in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

e. A nursing facility must apply for BCU eligibility on an annual basis in accordance with Section 266 of these rules. If the provider was not a BCU for a full cost report year, the twenty percent (20%) BCU day requirement will apply only to days beginning with the first day of BCU eligibility to the end of the year. ( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1702

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, and 42 CFR Sections 438, 440, and 457.

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

Under the CFR sections cited above, access to mental healthcare services cannot be more restrictive than access for medical/surgical services. The rule changes in this docket allow the Department flexibility to adjust requirements for authorizations and coverage to ensure that access to mental health services is consistent with the requirements in CFR. Companion Docket No. 16-0309-1702 is also publishing in this Bulletin.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 282 and 283**.

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 will have an estimated $121,572 impact to the State General Fund. There will be a federal fund spending authority impact of $300,114 in the Division of Medicaid from matching federal funds through Federal Medical Assistance Percentage (FMAP). This impact is due to removing restrictions for behavioral health care services to comply with federal requirements.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact William Deseron at (208) 364-1967.

DATED this 16th day of November, 2017.

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, and 42 CFR Sections 438, 440, and 457.

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

PUBLIC HEARING

Friday, October 13, 2017 – 2:00 p.m. (Local)

Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

TELECONFERENCE CALL-IN

Toll Free: 1-877-820-7831
Participant Code: 701700

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

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

Under the Code of Federal Regulations (CFR) sections cited above, access to mental healthcare services cannot be more restrictive than access for medical/surgical services. These rule changes allow the Department flexibility to adjust requirements for authorizations and coverage to ensure that access to mental health services is consistent with the requirements in CFR.

Specifically, inpatient psychiatric stays will be permitted for as long as they are medically necessary, and will be subject to the same reviews as general hospital stays. Participant eligibility for inpatient psychiatric stays are being defined to align with CFR restrictions. General hospital procedural guidelines are being changed to provide a psychiatric services structure with which to align. General hospital inpatient provisions are being changed to match current Medicaid practice and Centers for Medicare and Medicaid Services (CMS) requirements. Finally, under physician services, limitations for psychiatric evaluations and psychotherapy are being removed. Should the Department need to make adjustments to remain in compliance with federal requirements or to maintain appropriate utilization of services in the future, these changes will allow for modification for those needs.

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

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

The fiscal impact associated with this rule change is minimal to none. An analysis conducted by the Division of Medicaid concluded any potential impact is so minimal that requesting additional funds is not warranted at this time.

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 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, pages 39 and 40**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact William Deseron at (208) 364-1967.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1702

SUB AREA: ENHANCED INPATIENT *~~PSYCHIATRIC HOSPITAL~~* BEHAVIORAL HEALTH SERVICES (Sections 100 - 199)

100. INPATIENT *~~PSYCHIATRIC HOSPITAL~~* BEHAVIORAL HEALTH SERVICES.
~~In addition to~~ The Medicaid Enhanced Plan Benefits include psychiatric services covered under inpatient hospital services and inpatient *~~psychiatric hospital~~* behavioral health services covered in IDAPA 16.03.09 "Medicaid Basic Plan Benefits~~.~~." *~~the Medicaid Enhanced Plan Benefit include enhanced medically necessary services for certain individuals under the age of twenty-one (21) in free standing psychiatric hospitals (Institutions For Mental Disease).~~* *~~(3-19-07)~~*( )

~~101. (RESERVED)~~

10~~2~~1. INPATIENT *~~PSYCHIATRIC HOSPITAL~~* BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 700 through 70~~7~~6 apply to Inpatient *~~Psychiatric Hospital~~* Behavioral Health ~~s~~Services in this chapter of rules. Individuals over age sixty-five (65) are eligible for inpatient behavioral health services under this chapter of rule. *~~(3-19-07)~~*( )

~~01. Limitation Exemption. The ten (10) day limitation does not apply to participants who are eligible for inpatient psychiatric hospital services under this chapter of rule.~~ *~~(3-19-07)~~*

~~02. Individuals Over 65. Individuals over age sixty-five (65) are eligible for inpatient psychiatric hospital services under this chapter of rule.~~ *~~(3-19-07)~~*

10~~3~~2. -- 199. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1703

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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, 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:

The Department's Infant Toddler and Medicaid programs are both required by federal law (Section 1905(a) of the Social Security Act) to provide access and reimbursement for early intervention services. Early intervention service requirements will be removed from this chapter and added as a new Section in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." The rule text will be updated to support program eligibility, service coverage, limitations, provider, and reimbursement requirements. These changes will allow the Department more flexibility for collaboration within IDHW Divisions and ensure all Medicaid-eligible infants and toddlers receive the right preventive services, at the right time, through the best financial means for the State. Updates to references or other minor technical corrections may be made as needed. Companion Docket No. 16-0309-1703 is publishing in this bulletin.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 284 through 295**.

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

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

This proposed change impacts the Division of Medicaid and the Division of Family and Community Services. Currently both divisions support these services for children with special healthcare needs ages 0-3 through a combination of a federal grant and Medicaid benefits payments.

This rule will enable additional Medicaid coverage for these services, which will allow leveraging federal funds to support better services for Idaho. There is no overall impact to the general fund; however, a transfer of general funds between divisions will be necessary. In addition, the FACS division will require an increase of $1,129,800 in federal spending authority and will revert $1,126,700 in receipt spending authority.

The net impact will increase federal expenditures for these services but will not increase the general fund needs. This will allow us to increase services to children and use state general funds more efficiently.

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 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, page 41**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cindy Brock at (208) 364-1983.

DATED this 16th day of November, 2017.

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

PUBLIC HEARING

Tuesday, October 17, 2017 — 2:00 p.m. (Local)

Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

TELECONFERENCE CALL-IN

Toll Free: 1-877-820-7831
Participant Code: 626553

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

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

The Department's Infant Toddler and Medicaid programs are both required by federal law to provide access and reimbursement for early intervention services. This rule change is needed to streamline the processes between two Department Divisions and to resolve the current access issue. Currently, the Infant Toddler Program has a waiting list

of children, including Medicaid-eligible children, that are unable to access Part C, early intervention treatment services. This change will keep the State in compliance in both areas, provide a more streamlined approach between the two Divisions, and will ensure improved access to these services for participants.

Early intervention service requirements will be removed from this chapter and added as a new Section in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." The rule text will be updated to support program eligibility, service coverage, limitations, provider, and reimbursement requirements. These changes will allow the Department more flexibility for collaboration within IDHW Divisions and ensure all Medicaid-eligible infants and toddlers receive the right preventive services, at the right time, through the best financial means for the State. Updates to references or other minor technical corrections may be made as needed.

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

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

This proposed change impacts the Division of Medicaid and the Division of Family and Community Services. Currently both divisions support these services for children with special healthcare needs from birth through the end of their 36th month of age through a combination of a federal grant and Medicaid benefits payments.

This rule will enable additional Medicaid coverage for these services, which will allow leveraging federal funds to support better services for Idaho. There is no overall impact to the general fund; however, a transfer of general funds between divisions will be necessary. In addition, the FACS division will require an increase of $1,129,800 in federal spending authority and will revert $1,126,700 in receipt spending authority.

The net impact will increase federal expenditures for these services but will not increase the general fund needs. This will allow us to increase services to children and use state general funds more efficiently.

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 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, page 41**.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1703

660. CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.
In accordance with Section 1915i of the Social Security Act, the Department will pay for home and community based services provided by individuals or agencies that have entered into a provider agreement with the Department.

Services provided by a developmental disabilities agency ~~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)~~( )

661. CHILDREN'S HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of these rules, the definitions in Section 521 of these rules apply. Additionally, the following terms apply to the Children's Home and Community Based Services State Plan Option: (7-1-11)

01. Agency. A developmental disabilities agency (DDA) as defined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

02. Annual. Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. (7-1-11)

03. Clinical Supervisor. For the purposes of these rules, the clinical supervisor is the professional responsible for the supervision of DDA staff as outlined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)~~.~~." ~~or is the professional responsible for the child's IFSP as designated by the Infant Toddler Program.~~
~~(7-1-13)~~( )

04. Community. Natural, integrated environments outside of the home, school, or DDA center-based settings. (7-1-11)

05. Developmental Disabilities Agency (DDA). A DDA is an agency that is: (7-1-11)

a. A type of developmental disabilities facility, as defined in Section 39-4604(7), Idaho Code, that is non-residential and provides services on an outpatient basis; (7-1-11)

b. Certified by the Department to provide home and community based services to people with developmental disabilities, in accordance with these rules; (7-1-11)

c. A business entity, open for business to the general public; and (7-1-11)

d. Primarily organized and operated to provide home and community based services and the corresponding assessments to people with developmental disabilities. DDA services include evaluations, diagnostic, treatment, and support services that are provided on an outpatient basis to persons with developmental disabilities and may be community-based, home-based, or center-based in accordance with the requirements of this chapter. (7-1-11)

06. Home and Community Based Services State (HCBS) Plan Option. The federal authority under section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and individuals with disabilities, without determining that without the provision of services the individuals would require institutional level of care. (7-1-11)

07. Human Services Field. A particular area of academic study in health care, social services, education, behavioral science or counseling. (7-1-11)

~~***08. Infant Toddler Program**. The Infant Toddler Program serves children birth up to three (3) years of age (36 months), and must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include: adherence to procedural safeguards and time lines, use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs), provision of early intervention services in the natural environment, transition planning, and program enrollment and reporting requirements.~~ ~~(7-1-13)~~

0~~9~~8. Integration. The process of promoting a life for individuals with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of individuals with developmental disabilities. (7-1-11)

1~~0~~9. Paraprofessional. A person qualified to provide direct support services which include respite and habilitative supports. (7-1-11)

1~~1~~0. Professional. A person qualified to provide direct intervention services which include habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. (7-1-11)

1~~2~~1. Support Services. Support services may provide supervision for a participant, as well as may provide assistance to a participant by facilitating integration into the community. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. General Requirements for Program Documentation. The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following program documentation is required: (7-1-11)

a. Direct service provider information that includes written documentation of the service provided during each visit made to the participant, and contains, at a minimum, the following information: (7-1-11)

i. Date and time of visit; and (7-1-11)

ii. Intervention and support services provided during the visit; and (7-1-11)

iii. A statement of the participant's response to the service; and (7-1-11)

iv. Length of visit, including time in and time out; and (7-1-11)

v. Specific place of service. (7-1-11)

vi. A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-11)

02. Habilitative Supports Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the following must be completed: (7-1-11)

a. On a monthly basis, the habilitative support staff must complete a summary of the participant's response to the support service and submit the monthly summary to the clinical supervisor. (7-1-11)

b. The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the plan developer. (7-1-11)

03. Family Education Documentation. In addition to the general requirements listed in Subsection 664.01 of this rule, the DDA ~~*or Infant Toddler Program*~~ must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. ~~*(7-1-13)*~~( )

04. Reporting Requirements. The clinical supervisor must complete at a minimum, six- (6) month and annual provider status reviews for habilitative support services provided. These provider status reviews must be

completed more frequently, when so required on the plan of service. (7-1-11)

a. Documentation of the six- (6) month and annual reviews must be submitted to the plan monitor. (7-1-11)

b. The provider must use Department-approved forms for provider status reviews. (7-1-11)

665. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES. All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-11)

01. Respite. Respite services may be provided by an agency that is certified as a DDA and is capable of supervising the direct services provided, by an independent respite provider~~, or by the Infant Toddler Program~~. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite services must meet the following minimum qualifications: ~~(7-1-13)~~( )

a. Must be at least sixteen (16) years of age when employed by a DDA ~~or Infant Toddler Program~~; or ~~(7-1-13)~~( )

b. Must be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an independent respite provider; and (7-1-11)

c. Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant's guardian; and (7-1-11)

d. Have received instructions in the needs of the participant who will be provided the service; and (7-1-11)

e. Demonstrate the ability to provide services according to a plan of service; and (7-1-11)

f. Must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks"; and (7-1-11)

g. When employed by a DDA ~~or Infant Toddler Program~~, must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)." Independent respite providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. ~~(7-1-13)~~( )

02. Habilitative Support Staff. Habilitative supports must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided~~, or by the Infant Toddler Program~~. Providers of habilitative supports must meet the following minimum qualifications: ~~(7-1-13)~~( )

a. Must be at least eighteen (18) years of age; (7-1-11)

b. Must be a high school graduate or have a GED; (7-1-11)

c. Have received instructions in the needs of the participant who will be provided the service; (7-1-11)

d. Demonstrate the ability to provide services according to a plan of service; (7-1-11)

e. Must have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: (7-1-11)

i. Have previous work experience gained through paid employment, university practicum experience, or internship; or (7-1-11)

ii. Have on-the-job supervised experience gained through employment at a DDA ~~or the Infant Toddler Program~~ with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services, and a minimum of weekly face-to-face supervision with the clinical supervisor for a period of six (6) months while delivering services. ~~(7-1-13)~~( )

f. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports. (7-1-11)

g. In addition to the habilitative support qualifications listed in Subsections 665.02.a. through f. of this rule, habilitative support staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)

i. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education, or closely-related coursework; or (7-1-11)

ii. Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist. (7-1-11)

03. Family Education. Family education must be provided by an agency certified as a DDA and with staff who are capable of supervising the direct services provided~~, or by the Infant Toddler Program~~. Providers of family education must meet the following minimum qualifications: ~~(7-1-13)~~( )

a. Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college, and has: (7-1-11)

i. One (1) year experience providing care to children with developmental disabilities; (7-1-11)

ii. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; or (7-1-11)

b. Individuals working as Developmental Specialists for children ages birth through three (3) or three (3) through seventeen (17), and individuals certified as Intensive Behavioral Interventionist professionals prior to July 1, 2011, are qualified to provide family education until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013, to maintain his certification. (7-1-11)

c. Each professional providing family education services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide family education services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

04. Family Education for Children Birth to Three. In addition to the family education qualifications listed in Subsections 665.03.a. through 665.03.c. of this rule, family education staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 665.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 665.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Requirements for Clinical Supervision. All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in Section 685 of these rules. Clinical supervisor(s) are professionals employed by a DDA ~~*or the Infant Toddler Program*~~ on a continuous and regularly scheduled basis. ~~*(7-1-13)*~~( )

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA ~~*and the Infant Toddler Program*~~ must employ an adequate number of clinical

supervisors to ensure quality service delivery and participant satisfaction. ~~(7-1-13)~~( )

06. Requirements for Collaboration. Providers of home and community based services must coordinate with the family-centered planning team as specified on the plan of service. (7-1-11)

07. Requirements for Quality Assurance. Providers of children's home and community based state plan option services must demonstrate high quality of services through an internal quality assurance review process. (7-1-11)

08. DDA Services. In order for a DDA to provide respite, habilitative supports, and family education the DDA must be certified to provide support services. Each DDA is required to provide habilitative supports. (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. (7-1-16)

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)

684. CHILDREN'S WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All children's waiver services must be identified on the plan of service and authorized by the Department. The plan of service must be reviewed by a plan developer at least every six (6) months or at a frequency determined by the family-centered planning team. (7-1-11)

02. General Requirements for Program Documentation. Children's waiver providers must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant the following program documentation is required: (7-1-11)

a. Direct service provider information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-11)

i. Date and time of visit; and (7-1-11)

ii. Services provided during the visit; and (7-1-11)

iii. A statement of the participant's response to the service, including any changes in the participant's condition; and (7-1-11)

iv. Length of visit, including time in and time out; and (7-1-11)

v. Specific place of service. (7-1-11)

b. A copy of the above information ~~*will*~~ must be maintained by the independent provider~~, *Infant Toddler Program,*~~ or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ~~*(7-1-13)*~~( )

03. Program Implementation Plan Requirements. For each participant receiving intervention and family training services, the DDA ~~*or the Infant Toddler Program*~~ must develop a program implementation plan to determine objectives to be included on the participant's required plan of service. ~~*(7-1-13)*~~( )

a. All program implementation plan objectives must be related to a goal on the participant's plan of service. (7-1-11)

b. The program implementation plan must be written, implemented, and submitted to the plan developer within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the program implementation plan is not completed within this time frame, the participant's records must contain documented participant-based justification for the delay. (7-1-13)

c. The program implementation plan must be completed by the habilitative interventionist, and must include the following requirements: (7-1-11)

i. The participant's name. (7-1-11)

ii. A baseline statement. (7-1-11)

iii. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)

iv. Written instructions to the staff that may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

v. Identification of the type of environment(s) and specific location(s) where services will be provided. (7-1-11)

vi. A description of the evidence-based treatment approach used for the service provided. (7-1-11)

vii. When the child has a current positive behavior support plan, it must be incorporated into the program implementation plan. (7-1-11)

viii. When interdisciplinary training is provided, identification of the type of interdisciplinary training and the objectives related to the training must be included on the program implementation plan. (7-1-11)

ix. Target date for completion, not to exceed one (1) year. (7-1-11)

x. The program implementation plan must be reviewed and approved by the clinical supervisor, as indicated by signature, credential, and date on the plan. (7-1-13)

04. Reporting Requirements. The clinical supervisor must complete, at a minimum, six- (6) month and annual provider status reviews for habilitative intervention and family training services provided. These provider

status reviews must be completed more frequently when so required on the plan of service. (7-1-11)

a. Documentation of the six (6) month and annual reviews must be submitted to the plan developer. (7-1-11)

b. The provider must use Department-approved forms for provider status reviews. (7-1-11)

05. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the plan developer when any significant changes in the participant's condition, as defined by the family-centered planning team, are noted during service delivery. Such notification will be documented in the service record. (7-1-11)

06. Records Maintenance. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (7-1-11)

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: (7-1-11)

a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

d. Practitioner of the healing arts; (7-1-11)

e. Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)

f. Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)~~.~~." ~~*and is*~~ The DDA must be capable of supervising the direct services provided~~*, or by the Infant Toddler Program*~~. Providers of habilitative intervention must meet the following minimum qualifications: ~~*(7-1-13)*~~( )

a. Must hold at least a bachelor's degree in a human services field from a nationally-accredited university or college; (7-1-11)

b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)

c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)

d. Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. The individual must meet the requirements of the

Department-approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)

04. Habilitative Intervention for Children Birth to Three. In addition to the habilitative intervention qualifications listed in Subsections 685.03.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," or by an independent Medicaid provider under agreement with the Department~~, or by the Infant Toddler Program~~. Providers of therapeutic consultation must meet the following minimum qualifications: ~~(7-1-13)~~( )

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)

c. Therapeutic consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

d. Therapeutic consultation providers employed by a DDA ~~or the Infant Toddler Program~~ must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. ~~(7-1-13)~~( )

06. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," by an independent Medicaid provider under agreement with the Department~~, or by the Infant Toddler Program~~. Providers of crisis intervention must meet the following minimum qualifications: ~~(7-1-13)~~( )

a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.05 of this rule. (7-1-11)

b. Emergency intervention technician providers must meet the minimum habilitative support provider qualifications described under Subsection 665.02 of these rules. (7-1-11)

c. Crisis intervention providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

07. Continuing Training Requirements for Professionals. Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

08. Requirements for Clinical Supervision. All DD services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA ~~or the Infant Toddler Program~~ on a continuous and regularly scheduled basis. ~~(7-1-13)~~( )

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the

necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA ~~*and the Infant Toddler Program*~~ must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. ~~*(7-1-13)*~~( )

09. Requirements for Collaboration with Other Providers. Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided 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. (3-20-14)

10. Requirements for Quality Assurance. Providers of children's waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)

11. DDA Services. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1705

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the 2018 legislative session unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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(b), 56-264, and 56-1610, Idaho Code.

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

These rules comply with the class action settlement in *K.W. v. Armstrong*, No. 1:12- cv-00022-BLW (D. Idaho), and ensure uniform applicability of the health or welfare exception in Idaho Code. These rules allow all developmental disability waiver participants the option to pursue exception reviews. There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 5, 2017, Idaho Administrative Bulletin, **Vol. 17-7, pages 56-57**.

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:

The Department does not anticipate any fiscal impact either positive or negative for this rule change to any state general funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Karen Westbrook at (208) 364-1960.

DATED this 3rd day of November, 2017.

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 PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2017.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections: 56-202(b), 56-264, and 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 19, 2017.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This change adjusts existing processes to comply with the class action settlement in *K.W. v. Armstrong*, No. 1:12-cv-00022-BLW (D. Idaho), and to ensure uniform applicability of the health or welfare exception in Idaho Code Section 56-255(3)(e)(ii). The Department is deleting the restriction that limits exception reviews to only participants who require residential high or intense supportive living services. This allows all developmental disability waiver participants the option to pursue exception review.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1)(c), Idaho Code, the Governor has found that this temporary adoption of rule confers a benefit based on the class action settlement in *K.W. v. Armstrong*, and protects the participants' health and safety.

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

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

The Department does not anticipate any fiscal impact either positive or negative for this rule change to any state general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was deemed not feasible as these rule changes are necessary to comply with the class action settlement in *K.W. v. Armstrong*.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Karen Westbrook at (208) 364-1960.

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 26, 2017.

DATED this 9th day of June, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-1705

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 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. (7-1-16)

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. (7-1-16)

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*~~ or 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 S~~*ubs*~~ection 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 acknowledgment 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. (7-1-16)

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)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1706

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2018. The pending rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 and is also adopting a temporary rule. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code; House Bill 43 (2017); and Section 1915(i) of the Social Security Act (42 U.S.C. 1396n).

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 and a statement of any change between the text of the proposed rule and the text of the pending rule:

As part of the Jeff D settlement agreement and the adoption of HB 43 (2017) which is directly related to it, the Department has created the Youth Empowerment Services (YES) program for children with Serious Emotional Disturbance (SED). The YES program will provide medical and behavioral health assistance to this target population, including respite care. These rule changes are needed so that the Department can provide these services to YES Program participants in accordance with the Jeff D settlement agreement.

This rulemaking adds new sections of rules to administer services and supports to be delivered under 1915(i) authority as a Medicaid state plan option. This will include the service of respite care. (Section 1915(i) of the Social Security Act gives states the option to offer home and community-based services (HCBS), previously available only through a 1915(c) Home and Community Based Services (HCBS) waiver, through the state's Medicaid state plan.)

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 text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Changes have been made to both the pending and temporary rule that adds children with SED and the YES program under the Home and Community Based Services program. The complete text of the proposed rule was published in the October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 296-298**.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule confers a benefit in the form of new services. These new services are being called Youth Empowerment Services (YES), and several other chapters of rules are implementing changes with the same effective date of January 1, 2018, to meet the intent of the law and the court-ordered settlement agreement.

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 costs for the Youth Empowerment Services (YES) program were originally estimated in the fiscal note for House Bill 43 (2017) and funding was addressed in House Bill 313 (2017).

A revised version of this fiscal note is presented in the following paragraph.

This rulemaking will have no impact to the State General Fund, but will have a federal fund spending authority impact of $2,968,400 in the Division of Medicaid for the last 6 months of SFY 2018. The Division of Behavioral Health's Children's Mental Health program reverted $1,181,600 General Fund for services that do not draw a federal match in SFY 2018 under House Bill 313. The Division of Medicaid will leverage matching federal funds through Federal Medical Assistance Percentage (FMAP) funding. In future years, as additional services are implemented as required by the lawsuit settlement agreement, there is an anticipated annual ongoing cost of $8,300,000 ($2,363,200 General Fund/$5,936,800 federal funds).

In addition to the above fiscal impact, Rule Docket 16-0318-1701 in the 2018 legislative session is bringing forward sliding scale premiums for participants with income levels above 150% of the Federal Poverty Guidelines, as directed under HB 313 in the 2017 legislative session. It is anticipated that revenue generated through premium collections will also contribute to offsetting the fiscal impact of the implementation of these services.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the pending and temporary rule, contact Clay Lord at (208) 364-1979.

DATED this 3rd day of November, 2017.

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 PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code; House Bill 43 (2017); and Section 1915(i) of the Social Security Act (42 U.S.C. 1396n).

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

PUBLIC HEARING
Wednesday, October 18, 2017 — 9:00 a.m. (Local)

Central Idaho - DHW Office
3232 Elder Street
Conference Room D - East
Boise, ID 83705

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

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

As part of the Jeff D settlement agreement and the adoption of HB 43 (2017) which is directly related to it, the Department has created the Youth Empowerment Services (YES) program for children with Serious Emotional Disturbance (SED). The YES program will provide medical and behavioral health assistance to this target population, including respite care. These rule changes are needed so that the Department can provide these services to YES Program participants in accordance with the Jeff D settlement agreement.

This rulemaking adds new sections of rules to administer services and supports to be delivered under 1915(i) authority as a Medicaid state plan option. This will include the service of respite care. (Section 1915(i) of the Social Security Act gives states the option to offer home and community-based services (HCBS), previously available only through a 1915(c) Home and Community Based Services (HCBS) waiver, through the state's Medicaid state plan.)

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

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

The costs for the Youth Empowerment Services (YES) program were originally estimated in the fiscal note for House Bill 43 (2017) and funding was addressed in House Bill 313 (2017).

A revised version of this fiscal note is presented in the following paragraph:

This rulemaking will have no impact to the State General Fund, but will have a federal fund spending authority impact of $2,968,400 in the Division of Medicaid for the last 6 months of SFY 2018. The Division of Behavioral Health's Children's Mental Health program reverted $1,181,600 General Fund for services that do not draw a federal match in SFY 2018 under House Bill 313. The Division of Medicaid will leverage matching federal funds through Federal Medical Assistance Percentage (FMAP) funding. In future years, as additional services are implemented as required by the lawsuit settlement agreement, there is an anticipated annual ongoing cost of $8,300,000 ($2,363,200 General Fund/$5,936,800 federal funds).

In addition to the above fiscal impact, Rule Docket 16-0318-1701 in the 2018 legislative session is bringing forward sliding scale premiums for participants with income levels above 150% of the Federal Poverty Guidelines, as directed under HB 313 in the 2017 legislative session. It is anticipated that revenue generated through premium collections will also contribute to offsetting the fiscal impact of the implementation of these services.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because negotiated rulemaking was not feasible since these rule changes are not negotiable as the benefits included herein are court-ordered through the Jeff D settlement agreement.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Clay Lord at (208) 364-1979.

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 25, 2017.

DATED this 1st day of September, 2017.

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. 16-0310-1706

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: (7-1-16)

01. Children's Developmental Disability Services. Children's developmental disability services as defined in Sections 663 and 683 of these rules. (7-1-16)

02. Adult Developmental Disability Services. Adult developmental disability services as defined in Sections 645 through 659, 703, and 705 of these rules. (7-1-16)

03. Consumer-Directed Services. Consumer-directed services as defined in IDAPA 16.03.13, "Consumer-Directed Services." (7-1-16)

04. Aged and Disabled Waiver Services. Aged and disabled waiver services as defined in Section 326 of these rules. (7-1-16)

05. Personal Care Services. Personal care services as defined in Section 303 of these rules. (7-1-16)

***06. Services for Children with Serious Emotional Disturbance (SED)**. Services for children with serious emotional disturbance (SED) who are participants in the Youth Empowerment Services (YES) Program as defined in Section 638 of these rules.* ( )

(BREAK IN CONTINUITY OF SECTIONS)

634. ~~644.~~ (RESERVED)

YOUTH EMPOWERMENT SERVICES (YES)
HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 635-638)

635. YOUTH EMPOWERMENT SERVICES (YES) 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 children who are YES program participants. HCBS state plan option services must be delivered in accordance with Sections 635 through 638 of these rules. ( )

636. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of Sections 635 through 638 of these rules, the following terms are used as defined below. ( )

01. Idaho Behavioral Health Plan (IBHP). The Idaho Behavioral Health Plan is defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 011. ( )

02. Independent Assessment. A comprehensive clinical diagnostic assessment and a Department-approved assessment tool to identify the child's needs, strengths, and degree of functional impairment, administered by a Department-designated independent assessor. The assessment process also includes the following activities: ( )

a. Evaluation of the child's current behavioral health, living situation, relationships, and family functioning; ( )

b. Contacts, as necessary, with significant individuals such as family and teachers; and ( )

c. A review of information regarding the child's clinical, educational, social, and behavioral health, and juvenile/criminal justice history. ( )

03. Person-centered Service Plan. The person-centered service plan identifies the participant's physical and behavioral health services and supports needs. The person-centered service plan must be reviewed and updated by the Department or its designated representative at least every twelve (12) months, upon the participant's request, when new services are needed, or when there is a significant change in the participant's condition. ( )

04. Serious Emotional Disturbance (SED). The term "serious emotional disturbance" is defined in Section 16-2403, Idaho Code. ( )

05. YES Program Participant. A YES program participant is an Idaho resident under eighteen (18) years of age with a serious emotional disturbance as determined by an independent assessment. ( )

637. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: ELIGIBILITY REDETERMINATION.
YES program participant eligibility must be redetermined by an independent assessment every twelve (12) months. The Department may extend participant eligibility to allow for redetermination if the independent assessment is unavoidably delayed. ( )

638. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
The following services are covered for YES participants: ( )

01. Respite Care. Respite care provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver of a YES program participant. Respite care is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Payment and administration of respite care services will be done through the IBHP and will be established by the Department in the IBHP contract. ( )

02. Person-Centered Planning. A person-centered planning team, comprised of the participant, family members, and other support persons significant to the participant, will direct the development of the person-centered service plan through a process approved by the Department. The process will include support necessary to enable the participant and his family to make informed choices and decisions concerning the person-centered service plan. ( )

639. -- 644. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1707

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

Under a court-approved settlement agreement, the Department will use a new assessment tool to replace the SIB-R assessment tool. The Department uses assessment tools to determine developmental disability eligibility, waiver eligibility, skill level, and the participant's budget for services. Reference to the SIB-R assessment tool is being removed from this chapter.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 299-309**.

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

The fiscal impact to implement and use a new assessment tool is a total of $909,375. These costs are funded by 71.26% ($648,020) federal funds and 28.74% ($261,355) state general funds. The costs to the state are included in the SFY 2018 budget previously approved by the 2017 Legislature.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Karen Westbrook at (208) 364-1960.

DATED this 3rd day of November, 2017.

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

PUBLIC HEARING

Monday, October 23, 2017 — 3:00 p.m. (MDT)

Medicaid Central Office
3232 Elder Street
Conference Room D - West/East
Boise, ID 83705

TELECONFERENCE CALL-IN

Toll Free: 1-877-820-7831
Participant Code: 301388

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

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

Under a court-approved settlement agreement, the Department is implementing the use of a new assessment tool to replace the SIB-R assessment tool. The Department uses assessment tools to determine developmental disability eligibility, waiver eligibility, skill level, and the participant's budget for services. Reference to the SIB-R assessment tool is being removed from this chapter and will no longer be incorporated by reference. The Department-approved assessment tool is being defined in the chapter and all references to the SIB-R will be removed and replaced throughout this chapter. Any manuals for new assessment tools being used by the Department are not being incorporated by reference. Other amendments to these rules are for updating terminology and references in these rules as needed.

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

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

The fiscal impact to implement and use a new assessment tool is a total of $909,375. These costs are funded by 71.26% ($648,020) federal funds and 28.74% ($261,355) state general funds. The costs to the state were included in the SFY 2018 budget previously approved by the 2017 Legislature.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking because the change is being made to comply with a court-approved settlement agreement.

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 SIB-R Comprehensive Manual is being deleted from the documents that are incorporated by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Karen Westbrook at (208) 364.1960.

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 25, 2017.

DATED this 1st day of September, 2017.

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. 16-0310-1707

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following document: (3-19-07)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at http://www.ecfr.gov/cgi-bin/text-idx?SID=3ec1965dbf5044d8f79b25d4d58c4cd1&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0. (3-19-07)

02. CDT - 2007/2008 (Current Dental Terminology, Sixth Edition). Current Dental Terminology, Sixth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60601-9985, or may be ordered online at http://www.adacatalog.org. A copy is available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (5-8-09)

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-19-07)

04. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-19-07)

05. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-19-07)

06. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (3-19-07)

~~07. SIB-R Comprehensive Manual. Scales of Independent Behavior -- Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079.~~ (3-19-07)

0~~8~~7. **Travel Policies and Procedures of the Idaho State Board of Examiners**. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov/. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

503. DEVELOPMENTAL DISABILITY DETERMINATION: TEST INSTRUMENTS.
A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (3-19-07)

01. Test Instruments For Adults. ~~Unless contra-indicated, the following test instruments or subsequent revisions~~ A Department-approved assessment tool for conducting cognitive and functional assessments must be used to determine eligibility~~:~~. ~~(3-19-07)~~( )

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

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

02. Test Instruments for Children. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills. ~~Unless contraindicated, the most recent version of the following test instruments~~ A Department-approved assessment tool for conducting cognitive and functional assessments must be used with children~~:~~. ~~(7-1-11)~~( )

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

~~i. Bayley Scales of Infant Development, for ages birth through forty-two (42) months; (7-1-11)~~

~~ii. Stanford Binet Intelligence Scales, for ages two (2) years through adult; (7-1-11)~~

~~iii. Wechsler Preschool and Primary Scale of Intelligence, for ages two (2) years, six (6) months to seven (7) years, three (3) months; (7-1-11)~~

~~iv. Wechsler Intelligence Scale for Children, for ages six (6) through sixteen (16) years, eleven (11) months; or (7-1-11)~~

~~v. Wechsler Adult Intelligence Scale, for ages sixteen (16) years to adult. (7-1-11)~~

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

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

~~ii. Scales of Independent Behavior (SIB-R) for ages birth through adult; or (7-1-11)~~

~~iii. Mullen Scales of Early Learning (MSEL) for ages birth to three (3) years. (7-1-11)~~

(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. Department-Approved Assessment Tool. Any standardized assessment tool approved by the Department for use in determining developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant's budget. ( )

0~~6~~7. Exception Review. A clinical review of a plan that falls outside the established standards. (3-19-07)

0~~7~~8. 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)

0~~8~~9. Level of Support. An assessment score derived from ~~*the SIB-R*~~ a Department-approved assessment tool 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~~10. 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. (7-1-16)

1~~0~~1. 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)

1~~1~~2. 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)

1~~2~~3. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)

1~~3~~4. 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)

1~~4~~5. 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)

1~~5~~6. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

1~~6~~7. 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)

1~~7~~8. 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)

1~~8~~9. 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~~*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. (3-19-07)

2~~0~~1. 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)

2~~1~~2. 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)

2~~2~~3. 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)

509. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: ELIGIBILITY DETERMINATION.
The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments must be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/ID level of care for waiver services in accordance with Section 584 of these rules. (3-29-12)

01. Initial Assessment. For new applicants, an assessment must be completed within thirty (30) days from the date a completed application is submitted. (3-19-07)

02. Annual Assessments. Assessments must also be completed for current participants at the time of their annual eligibility redetermination. The assessor must evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (3-19-07)

a. The assessment process must be completed; and (3-19-07)

b. The assessor must provide the results of the assessment to the participant. (3-19-07)

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. A ~~SIB-R~~ Department-approved assessment tool will be administered by the Department for use in this determination. ~~(3-19-07)~~( )

04. ICF/ID Level of Care Determination for Waiver Services. The assessor will determine ICF/ID level of care for adults in accordance with Section 584 of these rules. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

512. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-29-10)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of developmental therapy and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. (7-1-13)

a. A medical, social and developmental history for each adult participant is completed by the Department or its contractor. (7-1-13)

b. Providers should obtain and utilize the medical, social developmental history documents generated by the Department or its contractor when one is necessary for adult program or plan development. (7-1-13)

04. ~~SIB-R~~ Department-Approved Assessment Tool. The results of ~~the SIB-R~~ a Department-approved assessment tool are used to determine the level of support for the participant. A current ~~SIB-R~~ Department-approved assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. ~~The SIB-R~~ A department-approved assessment tool for adults is completed by the Department or its contractor. Providers must obtain and utilize the document generated by the Department or its contractor when one is necessary for program or plan development. ~~(7-1-13)~~( )

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special

consideration. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. (3-29-12)

01. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-29-12)

a. The Department notifies each participant of his set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-29-12)

b. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. (3-29-12)

02. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision ~~*and have an SIB-R Support Level of Pervasive, Extensive, or Frequent*~~ as determined by a Department-approved assessment tool. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. ~~*(3-19-07)*~~( )

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent

injury to themselves or others. (3-19-07)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-19-07)

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

584. ICF/ID: CRITERIA FOR DETERMINING ELIGIBILITY.
Individuals who have intellectual disabilities or a related condition as defined in Section 66-402, Idaho Code, and Sections 500 through 503 of these rules, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/ID or receive services under one of Idaho's programs to assist individuals with intellectual disabilities or a related condition to avoid institutionalization in an ICF/ID, as indicated in Section 584.02 of these rules. To meet Title XIX and Title XXI entitlement for ICF/ID level of care and be eligible for services provided in an ICF/ID. The following must be met in Subsections 584.01 through 584.08 of these rules. (3-19-07)

01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. (3-19-07)

02. Active Treatment. Persons living in an ICF/ID, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain his functional level. (3-19-07)

a. Active treatment does not include: parenting activities directed toward the acquisition of age-appropriate developmental milestones; services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program or services; interventions that address age-appropriate limitations; or general supervision of children whose age is such that such supervision is required by all children of the same age. (3-19-07)

b. The following criteria/components will be utilized when evaluating the need for active treatment: (3-19-07)

i. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the participant and the interventions needed; and (3-19-07)

ii. Plan of Care. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. (3-19-07)

03. Must Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future. (3-19-07)

04. Care for a Child. The department may provide Medicaid to a child eighteen (18) years of age or younger, who would be eligible for Medicaid if they were in a medical institution and who are receiving, while living at home, medical care that would be provided in a medical institution, if the Department determines that the child requires the level of care provided in an ICF/ID. (3-19-07)

05. Functional Limitations. (3-19-07)

a. Persons Sixteen Years of Age or Older. Persons ~~(~~sixteen (16) years of age or older~~)~~ may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment ~~*(Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions)*~~ using a Department-approved assessment tool would qualify; or ~~*(3-19-07)*~~( )

b. Persons Under Sixteen Years of Age. Persons ~~(~~under sixteen (16) years of age~~)~~ qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or ~~*(3-19-07)*~~( )

06. Maladaptive Behavior. (3-19-07)

a. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on ~~*the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision*~~ a Department-approved assessment tool is minus twenty-two (-22) or less; or ~~*(3-19-07)*~~( )

b. Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or (3-19-07)

07. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 584.05 and 584.06 of these rules at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (3-19-07)

a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on ~~*the Woodcock Johnson SIB-R*~~ a Department-approved assessment tool up to minus seventeen (-17), minus twenty-two (-22) inclusive; or ~~*(3-19-07)*~~( )

b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on ~~*the Woodcock Johnson SIB-R*~~ a Department-approved assessment tool between minus seventeen (-17), and minus twenty-one (-21) inclusive; or ~~*(3-19-07)*~~( )

08. Medical Condition. Individuals may meet ICF/ID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services. (3-19-07)

09. Annual Redetermination for ICF/ID Level of Care for Community Services. The RMS staff

must redetermine the participant's continuing need for ICF/ID level of care for community services. Documentation will consist of the completion of a redetermination statement on the "Level of Care" form HW0083. Such documentation will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination. (3-19-07)

a. Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/ID eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. (3-19-07)

b. Developmentally Disabled Waiver. Individuals receiving developmentally disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

682. CHILDREN'S WAIVER SERVICES: ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 522 of these rules. Children's waiver participants must meet the following requirements: (7-1-11)

01. Age of Participants. The following waiver programs are available for children: (7-1-11)

a. Children's DD Waiver. Children's DD waiver participants must be birth through seventeen (17) years of age. (7-1-11)

b. Act Early Waiver. Act Early waiver participants must be three (3) through six (6) years of age. (7-1-11)

02. Eligibility Determinations. The Department must determine that: (7-1-11)

a. The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 683 of these rules were not made available; and (7-1-11)

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the family-centered planning team. Prior to any denial of services, it must be determined by the plan developer that services to correct the concerns of the team are not available. (7-1-11)

c. The average annual cost of waiver services and other medical services to participants would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs. (7-1-11)

d. Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (7-1-11)

03. Additional Act Early Waiver Requirements. In addition to the requirements listed in Subsections 682.01 and 682.02 of this rule, a participant must have the following characteristics to qualify for Act Early waiver services: (7-1-11)

a. An autism spectrum diagnosis; or (7-1-11)

b. Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on ~~*the Scales of Independent Behavior - Revised (SIB-R)*~~ a Department-approved assessment tool or other behavioral assessment indicators identified by the Department and a severe deficit, defined as having a composite full scale functional age equivalency of fifty percent (50%) or less of the participant's chronological age. ~~*(7-1-11)*~~( )

04. Children's Waiver Eligible Participants. A participant who is determined by the Department to be eligible for services under the children's waivers may elect not to use waiver services, but may choose admission to an ICF/ID. (7-1-11)

05. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the children's waivers for participants with developmental disabilities will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after June 30th of each new waiver year. (7-1-11)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.19 – RULES GOVERNING CERTIFIED FAMILY HOMES

DOCKET NO. 16-0319-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 67-5224 and 67-5291, Idaho Code. If the pending rule is acted on by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-3505, and 56-1005, Idaho Code.

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

Changes are being made to the proposed rules based on comments received from the public and advocates as well as for clarity and grammar. The changes in this rule docket are a complete rewrite of the chapter. The Department is publishing the complete chapter for the pending rules to ensure that all changes are seen in context of the full chapter rewrite. The Centers for Medicare and Medicaid Services, as a condition for approving Idaho's transition plan for implementing Home and Community Based Service standards, required the Department to develop an eviction process for residents living in Certified Family Homes that is comparable to Idaho's landlord tenant law. That required process is included in this rulemaking.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. The complete text of the proposed rule was published in the September 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 117-170**.

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 to dedicated funds for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Steve Millward at (208) 334-0706.

DATED this 16th day of November, 2017.

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 Sections 39-3505, and 56-1005, 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 20, 2017.

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 last major revision to this chapter occurred in 2006 which means that updates are needed to address changes regarding the health care environment, technology, and best practices that have occurred during the last 10 years. The changes in this docket show the underline and strikeout of all changes being made to the current rule which is a rewrite of IDAPA 16.03.19, "Rules Governing Certified Family Homes." Also, the Centers for Medicare and Medicaid Services, as a condition for approving Idaho's transition plan for implementing Home and Community Based Service standards, required the Department to develop an eviction process for residents living in Certified Family Homes that is comparable to Idaho's landlord tenant law.

Revisions and updates are being made regarding the following: admission process; adult hourly care; assessments; certification limitations; changes in location; definitions; elements of care; enforcement actions; eviction process; fire and life safety standards; medication policy; ongoing training requirements; physical home standards; plan of service; reporting and investigation of incidents and accidents; resident funds and finances; resident records; resident rights; variances and waivers; and voluntary home closures.

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

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

There is no anticipated fiscal impact to the State General Fund or to dedicated funds for this rule change. 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 May 3, 2017, Idaho Administrative Bulletin, **Vol. 17-5, pages 67-68**.

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: This chapter of rules has not be updated since 2006 and the American with Disabilities Guidelines in the Standards for Accessible Design have been updated. The Department is adopting the 2010 ADA - Standards for Accessible Design in this chapter of rule. Changes are for accessibility in homes being certified under these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Steve Millward at (208) 334-0706.

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 27, 2017.

DATED this 4th day of August, 2017.

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis

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. 16-0319-1701

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Sections 56-1005 and 39-3505, Idaho Code, to adopt and enforce rules and standards for Certified Family Homes. The Department is authorized under Sections 56-264 and 56-1007, Idaho Code, to adopt and develop application and certification criteria, and to charge and collect application and certification fees. Under Sections 56-1002, 56-1003, 56-1004, 56-1004A, 56-1005, and 56-1009, Idaho Code, the Department and the Board of Health and Welfare have prescribed powers and duties to provide for the administration and enforcement of Department programs and rules. ~~(3-21-12)~~( )

001. TITLE, SCOPE, AND EXCEPTIONS.

01. Title. These rules are cited as IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-11-06)

02. Scope. These rules set the minimum standards and administrative requirements for any ~~home that~~ care provider who is paid to care for an adult living in the care provider's home, when the adult is elderly or has a developmental disability, mental illness, or physical disability, and needs assistance with activities of daily living. ~~(4-11-06)~~( )

03. Exceptions to These Rules. These rules do not apply to the following: (4-11-06)

a. Any ~~home that~~ individual who provides only housing, meals, transportation, housekeeping or recreational and social activities. ~~(4-11-06)~~( )

b. Any health facility defined by Title 39, Chapter 13, Idaho Code. (4-11-06)

c. Any residential care or assisted living facility defined by Title 39, Chapter 33, Idaho Code. (4-11-06)

d. Any arrangement for care in a relative's home that is not compensated through a ~~federal or state~~ publicly-funded program. ~~(4-11-06)~~( )

e. Any home approved by the Department of Veterans Affairs as a "medical foster home" described in 38 CFR Part 17 and Sections 39-3502 and 39-3512, Idaho Code. ~~Homes that~~ Care providers who provide care to both veterans and non-veterans living in a "medical foster home" are not exempt from these rules. ~~(7-1-17)~~( )

04. State Certification to Supersede Local Regulation. These rules will supersede any program of any political subdivision of the state which certifies or sets standards for certified family homes. These rules do not supersede any other local regulations. (4-11-06)

002. WRITTEN INTERPRETATIONS.

There are no written interpretations for this chapter of rule. (4-11-06)

003. ADMINISTRATIVE APPEALS.
All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (4-11-06)

004. INCORPORATION BY REFERENCE.
The Americans with Disabilities Act Accessibility Guidelines, 28 CFR Part 36~~, *Appendix A to Part 36*~~ - 2010 ADA Standards for Accessible Design, is incorporated by reference. The internet website is http://www.ada.gov/~~*regs2010/ADAregs2010.htm*~~2010ADAstandards_index.htm. ~~*(4-11-06)*~~( )

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- INTERNET WEBSITE -- CONTACT INFORMATION.

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. (4-11-06)

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. (4-11-06)

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. (4-11-06)

b. The Division of Licensing and Certification main office is located at 3232 Elder Street, Boise, Idaho, 83705. ( )

04. Telephone Numbers.

a. The ~~*telephone number for the*~~ business office of the Idaho Department of Health and Welfare is (208) 334-5500. ~~*(4-11-06)*~~( )

b. The business office of the Division of Licensing and Certification is (208) 364-1959. ( )

c. The Program Manager of Certified Family Homes is (208) 334-0706. ( )

05. Internet Website.

a. The Department Internet website is www.healthandwelfare.idaho.gov. (4-11-06)

b. The Certified Family Home Internet website is www.cfh.dhw.idaho.gov. ( )

06. Regional Certifying Agent Contact Information. ( )

a. Region 1 - 1120 Ironwood Drive, Coeur d'Alene, ID 83814 - (208) 665-8807; ( )

b. Region 2 - 1118 F Street, Lewiston, ID 83501 - (208) 799-4438; ( )

c. Region 3 - 3402 Franklin Road, Caldwell, ID 83605 - (208) 455-7120; ( )

d. Region 4 - 1720 Westgate Drive, Boise, *ID* 83704 - (208) 334-0700; ( )

e. Region 5 - 803 Harrison Street, Twin Falls, ID 83301 - (208) 732-1515; ( )

f. Region 6 - 1070 Hiline Road, Pocatello, ID 83201 - (208) 239-6249; and ( )

g. Region 7 - 150 Shoup Avenue, Idaho Falls, ID 83402 - (208) 528-5721. ( )

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. ~~*The use or*~~ Any disclosure of confidential information ~~*related to*~~ used or disclosed in the course of the Department's ~~*client records covered by these rules*~~ business is subject to the restrictions in state or federal law, and must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records~~,~~." ~~*and federal Public Law 103-209.*~~ ~~*(4-11-06)*~~( )

02. Public Records Act. The Department ~~*of Health and Welfare*~~ will comply with Title 74, Chapter 1, Idaho Code, when requests for examin~~*ing*~~ation and of copying public records are made. Unless otherwise exempted, all public records in the custody of the Department of Health and Welfare are subject to disclosure. ~~*(4-11-06)*~~( )

007. -- 008. (RESERVED)

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

01. ~~*Compliance with*~~ Department Criminal History and Background Check Clearance. The provider, substitute caregivers, and all adults living in the home are required to ~~*comply*~~ complete a Department criminal history and background check and receive a clearance in compliance with IDAPA 16.05.06, "Criminal History and Background Checks." The resident is exempt from criminal history check requirements. ~~*(4-11-06)*~~( )

02. When Certification Can Be Granted. Prior to certification being granted: ( )

a. The provider must have a completed criminal history check, including clearance~~, *prior to certification.*~~ ; and ( )

b. Any other adult living in the home must have completed a self-declaration form, must be fingerprinted, and must not have any designated crimes listed in IDAPA 16.05.06, "Criminal History and Background Checks." ~~*(4-11-06)*~~( )

03. New Adults in the Home After Certification Is Granted. A new adult who plans to live in the home must complete a self-declaration form, must be fingerprinted, and must not have any designated crimes listed in IDAPA 16.05.06, "Criminal History and Background Checks," before moving into the home. Any adult who is a visitor in the home and leaves within thirty (30) days~~,~~ is not required to have a criminal history check but must not have unsupervised contact with the resident. ~~*(4-11-06)*~~( )

04. Minor Child Turns Eighteen. A minor child turning eighteen (18) and living in the home must complete a self-declaration form, must be fingerprinted, and must not have disclosed any designated crimes listed in IDAPA 16.05.06, "Criminal History and Background Checks," within thirty (30) days following the month of his eighteenth birthday. (4-11-06)

05. Substitute Caregiver. A substitute caregiver must complete a self-declaration form, be fingerprinted, and must not have disclosed any designated crimes listed in IDAPA 16.05.06, "Criminal History and Background Checks," prior to any unsupervised contact with the resident. (4-11-06)

06. Additional Criminal Convictions, Pending Investigations, or Charges. Once criminal history clearances have been received, the provider must ~~*immediately*~~ report to the Department any additional criminal convictions, pending investigation or charges for himself, any other adult living in the home or a substitute caregiver as described in Section 210 of these rules. ~~*(4-11-06)*~~( )

~~***07. Notice of Pending Investigations or Charges**. Once criminal history clearances have been received, the provider must immediately report to the Department when he, any other adult living in the home, or a substitute caregiver is charged with or under investigation for abuse, neglect or exploitation of any vulnerable adult or child, criminal charges, or when an adult protection or child protection complaint is substantiated.* *(4-11-06)*~~

010. DEFINITIONS AND ABBREVIATIONS -- A THROUGH K.

For the purposes of these rules, the following definitions apply: ( )

01. **Abuse**. A nonaccidental act of sexual, physical, or mental mistreatment or injury of the resident through the action or inaction of another individual. (4-11-06)

02. **Activities of Daily Living**. The performance of basic self-care activities in meeting an individual's needs to sustain him in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communicating, ~~continence, managing money,~~ mobility, and associated tasks. ~~(4-11-06)~~( )

03. **Adult**. A person who has attained the age of eighteen (18) years. (4-11-06)

04. **Alternate Caregiver**. A certified family home provider approved by the Department to care for a resident from another certified family home for up to thirty (30) consecutive days when the original provider is temporarily absent or unable to care for the resident. (4-11-06)

05. **Assessment**. The conclusions reached through evaluation of functional and cognitive ability using uniform criteria ~~developed by the Department and relevant councils for determining a person's need for care and services~~ that identifies the resident's strengths, weaknesses, risks and needs, and includes functional needs, medical needs and behavioral needs. ~~(4-11-06)~~( )

06. **Certificate**. A permit issued by the Department to operate a certified family home. (4-11-06)

07. **Certified Family Home**. A home certified by the Department to provide a family-styled living environment and care to one (1) or two (2) adults~~,~~ who are ~~un~~not able to reside ~~on~~ in their own home and who require care, help with activities of daily living, help with instrumental activities of daily living, protection and security, ~~and need~~ supervision, personal assistance or encouragement toward independence. The certified family home is referred to as "the home" in these rules. ~~(4-11-06)~~( )

08. **Certified Family Home Care Provider**. The adult member of the certified family home living in the home who is responsible for providing care to the residents and maintaining the home. The certified family home care provider is referred to as "the provider" in ~~this chapter of~~ these rules. ~~(4-11-06)~~( )

09. **Certifying Agent**. A person acting under the authority of the Department to participate in the certification, inspection, and regulation of a certified family home. ( )

10~~9~~. **Chemical Restraint**. The use of any medication that results or is intended to result in the modification of behavior for the purposes of discipline or convenience and not required to treat the resident's medical condition or symptoms. ~~(4-11-06)~~( )

11. **Core Issue**. Abuse, neglect, exploitation, inadequate care, inoperable fire detection or extinguishing systems with no fire watch in place pending the correction of the system, and situations in which advocates, representatives, and certifying agents are denied access to records, residents, or the home according to their respective authority. ( )

1~~0~~2. **Criminal Offense**. Any crime as defined in Section 18-111, Idaho Code, in 18 U.S.C. Section 4A1.2 (o), and 18 U.S.C. Sections 1001 through 1027. (4-11-06)

13. **Critical Incident**. Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a resident. ( )

1~~1~~4. **Department**. The Idaho Department of Health and Welfare. (4-11-06)

1~~2~~5. **Director**. The Director of the Idaho Department of Health and Welfare or his designee. (4-11-06)

1~~3~~6. **Exploitation**. The misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage. (4-11-06)

17. **Health Care Professional**. An individual licensed to provide health care within his respective discipline and scope of practice. ( )

1~~4~~8. **Immediate Jeopardy**. An immediate or substantial danger to a resident. (4-11-06)

***19. Inadequate Care**. The provider fails to provide services required to meet the terms of the negotiated plan of service or provide for room, board, activities of daily living, supervision, first aid, assistance and monitoring of medications, emergency intervention, coordination of outside services or a safe living environment, or engages in violations of residents' rights or takes residents who have been admitted in violation of the provisions of Section 39-3507, Idaho Code.* ( )

***20. Incident**. An actual or alleged minor event or situation that has impacted or has the potential to impact the resident's health or safety, but does not rise to the level of a critical incident.* ( )

~~15~~21. **Incidental Supervision**. Supervision provided by an individual approved by the provider to supervise the resident, not to exceed four (4) hours per week. (4-11-06)

2*2*. **Instrumental Activities of Daily Living**. The performance of secondary level activities that enable a person to live independently in the community, including preparing meals, accessing transportation, shopping, laundry, money management, housework, medication management, using tools and technology, and other associated tasks. ( )

011. DEFINITIONS AND ABBREVIATIONS -- L THROUGH Z.
For the purposes of these rules, the following definitions apply: ( )

01~~6~~. **Level of Care**. A categorical assessment of the resident's functional ability in any given activity of daily living, instrumental activity of daily living or self-preservation and the degree of care required in ~~*the*~~ that area~~s~~ ~~*of activities of daily living, supervision, response to emergency situation, mobility, medications and behavior management*~~ to sustain the resident in a daily living environment. ~~*(4-11-06)*~~( )

~~17~~02. **Neglect**. The failure to provide food, clothing, shelter or medical care to sustain the life and health of a resident. ~~*(4-11-06)*~~( )

~~18~~03. **Negotiated Service Agreement**. The agreement between the resident ~~*and*~~ or his representative, ~~*if applicable,*~~ and the ~~*home*~~ provider based on the resident's assessment, ~~*physician's*~~ health care professional's orders, ~~*if any,*~~ admission records, ~~*if any,*~~ and desires of the resident, that outlines services to be provided and the obligations of the ~~*home*~~ provider and the resident. This agreement is also known as a plan of service. ~~*(4-11-06)*~~( )

~~***19. Owner**. Any recognized legal entity, governmental unit, or person having legal ownership of the certified family home as a business operation.* *(4-11-06)*~~

04. **Personal Assistance**. The provision of care to the resident by the provider of one (1) or more of the following services: ( )

a. Assisting the resident with activities of daily living; ( )

b. Assisting the resident with instrumental activities of daily living; ( )

c. Arranging for supportive services; ( )

d. Being aware of the resident's general whereabouts; and ( )

e. Monitoring the activities of the resident while on the premises of the home to ensure the resident's health, safety and well-being. ( )

~~2~~05. **Plan of Service**. The generic term used in these rules to refer to the Negotiated Service Agreement,

Personal Care Plan, Plan of Care, Individual Support Plan, Support and Spending Plan, or any other comprehensive service plan. ~~(4-11-06)~~( )

~~21~~06. **PRN (Pro Re Nata)**. ~~A~~ PRN is an abbreviation meaning "when necessary" used for medication or treatment ordered by a ~~medical~~ health care professional to an individual allowing the medication or treatment to be given as needed. ~~(4-11-06)~~( )

~~22~~07. **Relative**. A person related by birth, adoption, or marriage to the ~~first~~ third degree, ~~and grandparent and grandchild~~ including spouses, parents, children, siblings, grandparents, grandchildren, aunts, uncles, nephews, nieces, great-grandparents, great-grandchildren, great-aunts, great-uncles, and first cousins. ~~(4-11-06)~~( )

~~23~~08. **Resident**. An adult who lives in a ~~C~~certified ~~F~~family ~~H~~home and who requires personal assistance or supervision ~~and one (1) or more of the following services: protection, assistance with decision-making and activities of daily living, or direction toward self care skills~~. ~~(4-11-06)~~( )

~~24~~09. **Substitute Caregiver**. An ~~individual approved~~ adult designated by the provider to provide care, services and supervision to the resident in the provider's certified family home for up to thirty (30) consecutive days. ~~(4-11-06)~~( )

10. Supervision. An administrative activity which provides the following: protection, guidance, knowledge of the resident's whereabouts and monitoring activities. ( )

11. Supportive Services. The specific services that are provided to the resident in the community and that are required by the plan of service or reasonably requested by the resident. ( )

12. Variance. A temporary exception not to exceed twelve (12) months issued by the Department to a certified family home allowing noncompliance with a specific standard required under these rules when the provider has shown good cause for such an exception and the variance does not endanger the health and safety of any resident. ( )

***13. Vulnerable Adult**. A person eighteen (18) years of age or older who is unable to protect himself from abuse, neglect, or exploitation due to physical or mental impairment that affects the person's judgment or behavior to the extent that he lacks sufficient understanding or capacity to make or communicate or implement decisions regarding his person as defined in Section 39-5302(10), Idaho Code.* ( )

14. Waiver. A permanent exception issued by the Department to a certified family home allowing noncompliance with a specific standard required under these rules when the provider has shown good cause for such an exception and the waiver does not endanger the health and safety of any resident. ( )

01~~1~~2. -- 099. (RESERVED)

100. CERTIFICATION REQUIREMENTS.
Certification is required in order to operate a certified family home in the State of Idaho. The Department will issue a certificate to a ~~home~~ provider when all certification requirements are met. ~~(4-11-06)~~( )

01. Certificate Issued in the Name of Provider. The certificate is issued in the name of the provider applying for certification, and only to the address of the home stated in the application. A new certificate is required if the provider or the location of the certified family home changes. (4-11-06)

02. Accessibility to the Home. The home, physical premises, and all records required under these rules, must be accessible at all times to the Department for the purposes of inspection, with or without prior notification. ~~(4-11-06)~~( )

03. Number of Residents in the Home. ~~A~~ The home cannot be certified for more than two (2) residents. A~~n exception~~ variance may be granted by the Department as described in Section 140 of these rules. ~~(4-11-06)~~( )

04. Certification Limitations. (4-11-06)

a. A home cannot be certified if it also provides room or board to any person who is not a resident or relative of the provider as defined by these rules ~~*or a family member*~~. A ~~*waiver*~~ variance may be granted by the Department when the individual receiving room or board is the spouse of the resident and does not require certified family home care or any higher level of care~~.~~. ~~*(4-11-06)*~~( )

b. A home cannot be certified as a certified family home and a children's foster home at the same time, unless a variance is granted by the Department. ~~*(4-11-06)*~~( )

c. ~~*A certified family home*~~ The provider, provider's relatives, and other adults living in the home ~~*may*~~ must not be the legal guardian of ~~*any*~~ the resident unless the ~~*guardian*~~ provider, provider's relative, or other adult living in the home is a ~~*parent, child, sibling, or grandparent*~~ relative of the resident. A variance may be granted by the Department when determined the guardianship is in the best interest of the resident. ~~*(4-7-11)*~~( )

d. The provider may not be absent from the certified family home for more than thirty (30) consecutive days when the home has an admitted resident. Appropriate care and supervision must be provided to the resident in the provider's absence as described in Section 300 of these rules. ( )

e. The provider's primary residence must be the certified family home. ( )

05. Certification Study Required. Following receipt of an acceptable application and other required documents, the Department will begin a certification study within thirty (30) days. The certification study, along with the application and other required material, will serve as the basis for issuing or denying a certificate. The study will include the following: (4-11-06)

a. A review of all material submitted; (4-11-06)

b. A ~~*scheduled*~~ home inspection; ~~*(4-11-06)*~~( )

c. An interview with the proposed provider; (4-11-06)

d. An interview with the provider's ~~*family, if*~~ relatives or other members of the household, when deemed necessary; ~~*(4-11-06)*~~( )

e. A review of the number, age, and sex of children or other adults in the home to evaluate the appropriateness of a placement to meet the needs of the resident; (4-11-06)

f. A medical or psychological examination of the provider or ~~*family*~~ other members of the household, ~~*if*~~ when the Department determines it is necessary~~;~~ ~~*and*~~ including a statement from a health care professional that the provider has the ability to provide adequate care to the resident and ensure a safe living environment; ~~*(4-11-06)*~~( )

g. Proof that the provider or provider's spouse is listed on the deed, mortgage, or lease of the home; and ( )

~~g~~h. Other information necessary to verify that the home is in compliance with these rules. (4-11-06)

06. Provider Training Requirements. As a condition of initial certification, ~~*all*~~ the provider~~s~~ must receive training in the following areas: ~~*(4-11-06)*~~( )

a. Resident rights; (4-11-06)

b. Certification in first aid and adult Cardio-Pulmonary Resuscitation (CPR) which must be kept current and include hands-on skills training; ~~*(4-11-06)*~~( )

c. Emergency procedures; (4-11-06)

d. Fire safety, including use and maintenance of fire extinguishers, ~~and~~ smoke alarms, and carbon monoxide alarms; ~~(4-11-06)~~( )

e. Completion of an approved "Assistance with Medications" course available through an Idaho Professional Technical Education Program or other course approved by the Department; and ~~(4-11-06)~~( )

f. Complaint investigation~~s~~ and inspection procedures. ~~(4-11-06)~~( )

07. Effect of Previous Revocation or Denial of Certificate or License. The Department is not required to consider the application of any applicant who has had a health care certificate or license denied or revoked until five (5) years have elapsed from the date of denial or revocation according to Section 39-3525, Idaho Code. (4-11-06)

101. APPLICATION FOR CERTIFICATION.
The applicant must apply for certification on forms provided by the Department, pay the application fee, and provide information required by the Department. (3-21-12)

01. Completed and Signed Application. A completed application form signed by the applicant. (4-11-06)

02. Statement to Comply. A written statement that the applicant has thoroughly read and reviewed this chapter and is prepared to comply with all of its provisions. (4-11-06)

03. Criminal History and Background ~~Clearance~~ Checks. Satisfactory evidence that the applicant and all adults living in the home are of reputable and responsible character, including ~~a~~ criminal history ~~clearance~~ and background checks as provided in Section 009 of these rules. ~~(4-11-06)~~( )

04. Statement Disclosing Revocation or Disciplinary Actions. A written statement that discloses any revocation or other disciplinary action taken or in the process of being taken against the applicant as a care provider in Idaho or any other jurisdiction, or a statement from the applicant stating he has never been involved in any such action. (4-11-06)

05. Electrical Inspection. A current statement from a licensed electrician or the local/state electrical inspector that all wiring in the home complies with applicable local code. (4-11-06)

06. Environmental Sanitation Inspection. If the home is not on a municipal water supply or sewage disposal system, a current statement is needed from the local environmental health agency that the water supply and sewage disposal system meet the legal standards. If the local environmental health agency cannot provide this information, the ~~home~~ applicant must obtain a statement to that effect. In addition, the applicant must provide a signed statement from a person in the business of servicing these systems that the water supply and sewage disposal system are in good working order. ~~(4-11-06)~~( )

07. Proof of Insurance. Proof of homeowner's or renter's insurance on the applicant's home ~~and the resident's belongings~~. For continued certification, the provider must ensure that insurance ~~must be~~ is kept current. ~~(4-11-06)~~( )

08. List of Individuals Living in the Home. A list of all individuals living in the home at the time of application and their relationship to the applicant. (4-11-06)

09. Payment of Application Fee. Payment of the application fee required in Section 109 of these rules. (3-21-12)

10. Other Information as Requested. Other information that may be requested by the Department for the proper administration and enforcement of the provisions of ~~this chapter~~ these rules. ~~(4-11-06)~~( )

11. Termination of Application Process. Failure of the applicant to cooperate with the Department in the application process will result in the termination of the application process. Failure to cooperate means that the information described in Section 101 of these rules is not provided in a timely manner, or not provided in the form requested by the Department, or both. (4-11-06)

102. -- 108. (RESERVED)

109. APPLICATION AND CERTIFICATION FEES FOR CERTIFIED FAMILY HOMES.

01. Application Fee Amount. An ~~*provider*~~ applicant is required to pay to the Department at the time of application a one-time non-refundable application fee of one hundred fifty ($150) dollars. ~~*(3-21-12)*~~( )

02. Payment of Application Fees. The application fee is required for the following: ( )

a. Upon application to become a certified family home care provider; ( )

b. When an application is terminated or the home closes, the applicant must pay the application fee again to reapply for certification; or ( )

c. When the home will be operated by a new care provider. ( )

0~~2~~3. Certification Fees. ~~*A*~~ The provider is required to pay to the Department a certification fee of twenty-five ($25) dollars per month. This amount ~~*will be*~~ is billed to the provider quarterly, and is due and payable within thirty (30) days of date of the invoice. ( )

a. Failure of the provider to pay certification fees when due may cause the Department to take enforcement action described in Section 913 of these rules. ~~*(3-21-12)*~~( )

b. Monthly certification fees paid in advance for the home will be refunded when the provider operates the home for less than fifteen (15) days during any given month for which payment was received by the Department. An advanced payment refund may be paid when the provider voluntarily closes the home as provided in Section 115 of these rules, or involuntarily closes the home due to an enforcement remedy imposed by the Department. ( )

110. ISSUANCE OF CERTIFICATE.

01. Certificate. A certificate is valid for no more than twelve (12) months from the date of approval. The certificate ~~*will*~~ expires at the end of the stated period unless it is continued in effect by the Department as provided in S~~*ubs*~~ection 11~~*0*~~1~~*.03.c*~~. of these rules. ~~*(4-11-06)*~~( )

a. The initial certificate requires a scheduled home inspection by ~~*the Department*~~ a certifying agent. ~~*(4-11-06)*~~( )

b. The certificate is valid only for the location and person named in the application and is not transferable or assignable~~;~~. ~~*(4-11-06)*~~( )

c. The certificate must be available at the home upon request. ~~*(4-11-06)*~~( )

02. Temporary Certificate. A temporary certificate may be issued to allow time for the provider to meet all certification requirements without a lapse in certification when the provider plans to relocate to a residence within the state and plans to continue operation of a certified family home. A temporary certificate is valid for no more than sixty (60) days from the date of approval. ( )

a. At least thirty (30) days prior to moving into a new residence, the provider must notify the certifying agent for the region in which the new home will be located as listed in Section 005 of these rules. Prior to moving into the new residence, the provider must submit to the certifying agent the following: ( )

i. A completed application form as required in Section 101 of these rules. An application fee is not required for only a change of location of the home; ( )

ii. An electrical inspection for the new residence as required in Section 101 of these rules; ( )

iii. Inspection and approval of any fuel-fired heating system in the new residence as required in Section 600 of these rules; and ( )

iv. Other information requested by the Department to ensure the new residence is appropriate for use as a certified family home and safe for occupation. ( )

b. The Department will issue a temporary certificate upon review and approval of the information required under Subsection 110.02 of this rule. ( )

c. The provider must coordinate with the certifying agent an inspection of the new residence to occur prior to the expiration of the temporary certificate and be prepared to demonstrate compliance with this chapter of rules during the home inspection. ( )

d. The Department will issue a certificate as described in Subsection 110.01 of this rule when it determines that the home is in compliance with these rules. ( )

02~~.~~3. Provisional Certificate. A provisional certificate may be issued to ~~a~~ the home as provided in Section 909 of these rules ~~that~~ when it is not in substantial compliance with these rules ~~if~~ and the deficiencies do not adversely affect the health or safety of the resident and are not likely to continue beyond six (6) months.
~~(4-11-06)~~( )

a. A ~~P~~provisional certificate~~s~~ may be issued for up to six (6) months and ~~are~~ is contingent on compliance with the conditions for the provisional certificate and implementation of an approved plan to correct all deficiencies prior to the expiration of the provisional certificate. ~~(4-11-06)~~( )

b. A provisional certificate may be replaced with a certificate when the Department has ~~revisited~~ determined the home is in substantial compliance with these rules prior to the expiration of the provisional certificate ~~and has determined that the home qualifies for a certificate~~. ~~(4-11-06)~~( )

c. A certified family home will not be issued more than one (1) provisional certificate in any twelve (12) month period. ~~(4-11-06)~~( )

~~03~~111. RENEWAL OF CERTIFICATE.
~~To renew the certificate, t~~The provider must submit a written request on a form provided by the Department to renew the home's certificate at least thirty (30) days prior to the expiration of the existing certificate. The completed renewal application form and any required documentation must be returned to the ~~Department~~ regional certifying agent where the home is located as listed in Section 005 of these rules ~~at least thirty (30) days prior to the expiration of the existing certificate~~. ~~(4-11-06)~~( )

~~a~~01. Home Inspection. A home inspection by a certifying agent is required the year after the initial home certification study and at least every twenty-four (24) months thereafter. The home inspection will consist of the elements of the certification study as required in Section 100 of these rules. ~~(4-11-06)~~( )

~~b~~02. Desk Review. ~~If~~ When the Department determines a home inspection is not required to renew the certificate, the Department may conduct a desk review by written notification to the provider. ~~t~~The provider must submit the renewal application to the certifying agent and copies of the following documentation ~~to renew the certificate~~: ~~(4-11-06)~~( )

~~i~~a. Current first aid and adult CPR cards; ~~(4-11-06)~~( )

~~ii~~b. Furnace, well, and fireplace inspection reports, as applicable; (4-11-06)

c. Septic system inspection or pumping report, as applicable, when the previous inspection is older than five (5) years; ( )

~~iii~~**d.** Annual fire extinguisher inspection reports, or sales receipts for fire extinguishers *that comply* with Section 600 of these rules that are less than twelve (12) months old; ~~(4-11-06)~~( )

~~iv~~**e.** ~~Fire l~~Log of smoke ~~detector checks~~ and carbon monoxide alarm tests, fire extinguisher ~~checks~~ examinations, emergency plan reviews, and fire drill and evacuation summaries; ~~(4-11-06)~~( )

~~v~~**f.** Training logs; (4-11-06)

~~vi~~**g.** List of individuals currently living in the home and individuals who moved in and out of the home during the year; (4-11-06)

h. Proof that the provider or provider's spouse is listed on the deed, mortgage, or lease of the home; ( )

~~vii~~**i.** Proof of homeowner's or renter's insurance; (4-11-06)

~~viii~~**j.** Request for a waiver, ~~or~~ variance, or renewal of ~~waiver and~~ a variance that meets the requirements in Sections 120 through 140 of these rules as applicable; and ~~(4-11-06)~~( )

~~i~~x**k.** Other information as requested by the Department. (4-11-06)

~~c~~**03.** **Validity of Existing Certificate**. The existing certificate, unless suspended or revoked, remains valid until the Department has acted on the renewal application ~~renewal~~ when the ~~renewal~~ application and supporting documentation is filed in a timely manner with the certifying agent. ~~(4-11-06)~~( )

~~04~~112. CHANGE OF ~~OWNERSHIP~~ PROVIDER ~~CERTIFICATION REQUIREMENTS~~ OR LOCATION.

01. Change of Provider. Certificates are not transferable or assignable from one (1) individual to another ~~or from one (1) location to another~~. The home must be ~~re~~certified using the same procedure as a new home that has never been certified when a change of ~~ownership, lease, or location~~ care provider occurs. ~~(4-11-06)~~( )

02. Change of Location. Certificates are not transferable or assignable from one (1) location to another. When a change of location occurs, the provider's new home must be: ( )

a. Certified using the same procedure as required in Section 100 of these rules for a new home that has never been certified; or ( )

b. Temporarily certified by the procedure described in Section 110 of these rules. ( )

~~05~~113. DENIAL OF APPLICATION FOR CERTIFICATE.
The Department may deny the application for issuance of a certificate when conditions exist that endanger the health, safety, or welfare of any resident or when the home is not in substantial compliance with these rules. Additional causes for denial of an application for a certificate include the following: ~~(4-11-06)~~( )

~~a~~**01. False or Incomplete Information**. The applicant or provider has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; ~~(4-11-06)~~( )

~~b~~**02. Convictions**. The applicant or provider has been convicted of fraud, gross negligence, abuse, assault, battery or exploitation; ~~(4-11-06)~~( )

~~c~~**03. Other Criminal Offense**. The applicant or provider has been convicted of a criminal offense within the past five (5) years, other than a minor traffic violation or similar minor offense; ~~(4-11-06)~~( )

~~d~~**04. Denial or Revocation of Health Care License**. The applicant or provider has been denied or has

had revoked any health facility license, residential care or assisted living facility license, or certified family home certificate; ~~(4-11-06)~~( )

~~e~~05. **Operation Without a License.** The applicant or provider has been ~~convicted of operating~~ found to have operated a health facility, residential care or assisted living facility, or certified family home without a license or certificate; ~~(4-11-06)~~( )

~~f~~06. **Court Ordered.** A court has ordered that the applicant or provider must not operate a health facility, residential care or assisted living facility, or certified family home; ~~(4-11-06)~~( )

~~g~~07. **Registries or Exclusion List.** The applicant or provider is listed on the statewide Child Abuse Registry, Adult Protection Registry, Sexual Offender Registry, or Medicaid exclusion lists; or ~~(4-11-06)~~( )

~~h~~08. **Control or Influence.** The applicant or provider is directly under the control or influence of any person who is described in Subsections ~~110.05.a. through 110.05.g.~~ 113.01 through 113.07 of ~~these~~ this rule~~s~~. ~~(4-11-06)~~( )

~~**06. Revocation of Certificate.** The Department may revoke any certificate when conditions exist which endanger the health, safety, or welfare of any resident, or when the home is not in substantial compliance with these rules as described in Section 913 of these rules.~~ ~~(4-11-06)~~

0~~7~~9. **Procedure for Appeal of Denial ~~or Revocation~~ of a Certificate.** ~~(4-11-06)~~( )

a. Immediately upon denial of any application for a certificate, ~~or revocation of a certificate,~~ the Department will notify the applicant or provider in writing by certified mail or by personal service of its decision, the reason for its decision, and how to appeal the decision. ~~(4-11-06)~~( )

b. The appeal is subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (4-11-06)

~~08~~114. **FAMILY HOME OPERATING WITHOUT A CERTIFICATE.**

01. Operating Without Certificate. A person found to be operating a family home without first obtaining a certificate may be referred for criminal prosecution. ( )

02. Placement or Transfer of Resident. Upon discovery of a family home operating without a certificate, the Department ~~will refer~~ may transfer residents to the appropriate placements or refer to *the local* adult protective services agency ~~if~~ when: ~~(4-11-06)~~( )

a. There is an immediate threat to any resident's health and safety; or (4-11-06)

b. The individual operating the home does not cooperate with the Department to apply for certification, meet certification standards and obtain a valid certificate. ~~(4-11-06)~~( )

~~111. -- 114. (RESERVED)~~

115. VOLUNTARY CLOSURE OF THE HOME.
When choosing to voluntarily close the home, the provider must provide written notice to the certifying agent in the region where the home is located as listed in Section 005 of these rules. The notification must include the following: ( )

01. Date of Notification. ( )

02. Provider's Certificate. A copy of the certificate, or information from the certificate that includes: ( )

a. Provider's name; ( )

b. Address of the home; and ( )

c. Certificate number. ( )

03. Closure Date. The written notice must include the planned closure date. The Department will not refund or prorate prepaid *certification fees* on retroactive closures. ( )

04. Discharge Plans. If applicable, discharge plans for current residents must accompany the written notice. ( )

115~~5~~6. REQUIRED ONGOING TRAINING.

~~*All*~~ The provider~~s~~ must document a minimum of eight (8) hours per year of ongoing, relevant training in the provision of supervision, services, and care. ~~*The training must consist of at least four (4) hours of classroom training. The remaining four (4) hours may be independent study or classroom training. Up to two (2) hours of ongoing first aid or CPR will count toward the eight (8) hour requirement. The initial provider training required in Subsection 100.06 of these rules will count toward the first year's eight (8) hour training requirement.* (4-11-06)~~( )

01. Initial Provider Training. The initial provider training required in Section 100 of these rules satisfies the eight (8) hour training requirement for the first year of certification. ( )

02. Type of Training. ( )

a. Interactive training means the provider is able to ask questions of a live instructor and receive answers in real time. The instructor must be a professional or a recognized authority in his subject matter. At least half of the required ongoing training hours each year must consist of interactive training. ( )

b. Independent study means any training not provided by a live instructor. The remaining required training hours may be independent study through books, articles, videos, online courses, and other resources. ( )

03. Content of Training. ( )

a. Resident specific. At least half of the required ongoing training hours each year must be devoted to the specific conditions, diagnoses and needs of admitted residents, when residents are admitted. ( )

b. General topics. The remaining hours may be devoted to other topics related to care giving, health or safety. Up to two (2) hours of first aid or adult CPR training will count toward the annual requirement. ( )

04. Documentation of Training. The provider must document *ongoing* training. The documentation must include: ( )

a. Topic of the training with a brief description; ( )

b. Source of training, including *the name of the* instructor or author; ( )

c. Number of hours; ( )

d. Type and content of training: ( )

i. Interactive or independent; and ( )

ii. Resident specific or general. ( )

116~~7~~. -- 119. (RESERVED)

120. WAIVERS.

The Department may grant permanent waivers. The decision to grant a waiver ~~*in one (1)*~~ for a home or provider is not a precedent or applicable to any other home or provider and has no force of effect in any other proceeding. ~~*(4-11-06)*~~( )

01. Written Request. ~~*A*~~ The provider must submit a written request for a waiver ~~*must be submitted*~~ to the ~~*Department*~~ regional certifying agent where the home is located as listed in Section 005 of these rules prior to any planned noncompliance with any rule under this chapter. The appropriateness of granting a waiver is determined by the Department. The request must include the following: ~~*(4-11-06)*~~( )

a. Reference to the section of the rules for which the waiver is requested; (4-11-06)

b. Reasons that show good cause ~~*why the*~~ for granting the waiver ~~*should be granted*~~, including any extenuating circumstances and any compensating factors or conditions that may have bearing on the waiver, such as additional floor space or additional staffing; and ~~*(4-11-06)*~~( )

c. ~~*Written documentation*~~ A signed statement from the provider that assures the resident's health and safety will not be jeopardized if the waiver is granted. The statement must include an agreement to implement any special conditions the Department requires. ~~*(4-11-06)*~~( )

02. ~~*Waiver Expiration*~~ Special Conditions. ~~*A*~~ When granting a waiver ~~*may be granted for a period of no more than twelve (12) months*~~, the Department may require the provider to meet special conditions while the waiver is in effect to ensure the health and safety of residents. ~~*(4-11-06)*~~( )

~~***03. Waiver Renewal**. If the provider wishes to renew a waiver, he must submit a written request to the Department. The appropriateness of renewing a waiver will be determined by the Department.* *(4-11-06)*~~

0~~4~~3. Waiver Not Transferable. A waiver granted under Section 120 of this rule is not transferable to any other provider, ~~*address*~~ home, or resident. ~~*(4-11-06)*~~( )

121. GENERAL VARIANCES.
The Department may grant temporary variances that may be effective for up to twelve (12) months at a time. The decision to grant a variance for a home or provider is not a precedent or applicable to any other home or provider and has no force of effect in any other proceeding. ( )

01. Written Request. The provider must submit a written request for a variance to the regional certifying agent where the home is located as listed in Section 005 of these rules prior to any planned noncompliance with any rule under this chapter. The appropriateness of granting a variance is determined by the Department. The request must include the following: ( )

a. Reference to the section of the rules for which the variance is requested; ( )

b. Reasons that show good cause for granting the variance, including any extenuating circumstances and any compensating factors or conditions that may have bearing on the variance, such as additional floor space or additional staffing; and ( )

c. A signed statement from the provider that assures resident health and safety will not be jeopardized if the variance is granted, including an agreement to implement any special conditions the Department may require. ( )

02. Special Conditions. When granting a variance, the Department may require the provider to meet special conditions while the variance is in effect to ensure the health and safety of residents. ( )

03. Variance Renewal. To renew a variance, the provider must submit a written request to the regional certifying agent where the home is located as listed in Section 005 of these rules at least thirty (30) days prior to expiration of the variance. The request for renewal must include *the information* required in Subsection 121.01 of this rule. The appropriateness of renewing a variance is determined by the Department. *( )*

04. Variance Not Transferable. A variance granted under Section 121 of this rule is not transferable to any other provider, home, or resident. ( )

122. REVOKING A WAIVER OR VARIANCE.
The Department may revoke a waiver or variance. ( )

01. Causes for Revocation. Revocation of a waiver or variance may occur when: ( )

a. The provider has not met the special conditions associated with granting the exception; ( )

b. Conditions within the home have changed such that an exception is no longer prudent; or ( )

c. The health and safety of residents have otherwise been compromised. ( )

02. Written Notice. The Department will provide written notice to the provider when a waiver or variance is revoked, including the reason for the revocation. ( )

03. Time Frame to Comply. The provider must comply with the rule for which the waiver or variance is revoked according to the following time frames: ( )

a. Immediately upon notification, when there is a threat to the life or safety of residents; or ( )

b. Within thirty (30) days of notification, when there is no threat to the life or safety of residents. ( )

12~~1~~3. -- 129. (RESERVED)

130. NURSING FACILITY LEVEL OF CARE ~~*WAIVER REQUIREMENTS*~~ VARIANCE.
A certified family home may care for one (1) resident who requires nursing facility level of care as defined in Section 39-1301(b), Idaho Code, without obtaining a ~~*waiver*~~ variance. A home seeking to provide care to two (2) residents who require nursing facility level of care must request a ~~*waiver*~~ variance in writing from the Department as required in ~~*Section 39-3554, Idaho Code*~~ Section 121 of these rules. ~~*(4-11-06)*~~( )

01. Conditions for a ~~*Waiver*~~ Variance. The Department ~~*will*~~ may issue a written ~~*waiver*~~ variance permitting the arrangement when: ~~*(4-11-06)*~~( )

a. Each of the residents provides a written statement to the Department requesting the arrangement; (4-11-06)

b. Each of the residents making the request is competent, informed, and has not been coerced; (4-11-06)

c. The Department finds the arrangement safe and effective. (4-11-06)

02. Revoking a ~~*Waiver*~~ Variance. The Department will revoke the ~~*waiver*~~ variance when: ~~*(4-11-06)*~~( )

a. There is a threat to the life or safety of either resident; (4-11-06)

b. One (1) of the residents leaves the home permanently; (4-11-06)

c. One (1) of the residents notifies the Department in writing that he does not wish to live in the home with the other resident; or (4-11-06)

d. The Department finds the arrangement is no longer safe and effective. (4-11-06)

03. ~~*Waiver*~~ Variance Not Transferable. A ~~*waiver*~~ variance granted under Subsection 130.01 of this

rule is not transferable to any other provider, ~~address~~ home, or resident. ~~(4-11-06)~~( )

131. -- 139. (RESERVED)

140. ~~EXCEPTION~~ VARIANCE TO THE TWO RESIDENT LIMIT.

01. Application for ~~Exception~~ Variance. ~~A home~~ The provider may apply ~~to~~ *on forms provided by* the Department for a~~n exception~~ variance to the two (2) resident limit in order to care for three (3) or four (4) residents on a per resident basis prior to any new admissions. *The application must be submitted to the certifying agent where the home is located as listed in Section 005 of these rules. The appropriateness of granting the variance is determined by the Department.* ~~(4-11-06)~~( )

02. Criteria for Determination. The Department will determine if safe and appropriate care can be provided based on residents' needs. The Department will consider, at a minimum, the following factors in making its determination: ~~(4-11-06)~~( )

a. Each current or prospective resident's physical, mental and behavioral status and history; (4-11-06)

b. The household composition including the number of adults, children and other family members requiring care from the provider; (4-11-06)

c. The training, education, and experience of the provider to meet each resident's needs; (4-11-06)

d. Potential barriers that might limit ~~resident safe access to and exit from the rooms in~~ egress from and ingress to the home; ~~(4-11-06)~~( )

e. The number and qualifications of care givers in the home; (4-11-06)

f. The desires of the prospective and current residents; (4-11-06)

g. The individual and collective hours of care needed by the residents; (4-11-06)

h. The physical layout of the home and the square footage available to meet the needs of all persons living in the home; and (4-11-06)

i. If a~~n exception~~ variance to the two (2) resident limit would result in two (2) or more residents who require nursing facility level of care living in the home, then the application for the variance must also include the information required in Section 130 of these rules. ~~(4-11-06)~~( )

03. Other Employment. A ~~P~~provider~~s of~~ who is granted a variance to admit three (3) or four (4) ~~bed homes~~ residents must not have other gainful employment outside the home unless: ~~(4-11-06)~~( )

a. The total direct care time for all residents~~,~~ as reflected by their plans of service and assessments or, if not indicated by these documents for a publicly-funded program, the time that the program bases its payment, does not exceed eight (8) hours per day; ~~(4-11-06)~~( )

b. The provider is immediately available to meet resident needs as they arise; and (4-11-06)

c. Each resident is supervised at all times unless the assessment or plan of service indicates the resident may be left unattended for designated periods of time. (4-11-06)

04. Additional Training. A ~~P~~provider~~s of~~ who is granted a variance to admit three (3) or four (4) ~~bed homes~~ residents must obtain additional training to meet the needs of the residents as ~~determined necessary by the Department.~~ follows: ~~(4-11-06)~~( )

a. A provider who cares for three (3) residents must obtain twelve (12) hours per year of ongoing relevant training as required in Section 116 of these rules. ( )

b. A provider who cares for four (4) residents must obtain sixteen (16) hours per year of ongoing relevant training as required in Section 116 of these rules. ( )

05. ~~Exception~~ Variance Nontransferable. A~~n exception~~ variance to care for more than two (2) residents ~~will~~ is not ~~be~~ transferable to another provider, ~~address~~ home, or resident. ~~(4-11-06)~~( )

06. Reassessment of ~~Exception~~ Variance. A~~n exception~~ variance to care for more than two (2) residents must be reassessed at least annually and when either of the following occurs: ~~(4-11-06)~~( )

a. Each time a new admission is considered; or (4-11-06)

b. When there is a significant change in any of the factors specified in Subsection 140.02 of ~~these~~ this rule~~s~~. ~~(4-11-06)~~( )

07. Annual Home Inspection. A certified family home with a~~n exception~~ variance to care for more than two (2) residents must have a home inspection by a certifying agent at least annually. ~~(4-11-06)~~( )

08. Shared Sleeping Rooms. In addition to the requirements in Section 700 of these rules, ~~no~~ *the provider must not allow* more than two (2) residents ~~will be housed in~~ *to share* any ~~multi-bed~~ *one (1)* sleeping room. ~~(4-11-06)~~( )

09. Fire Drill Frequency. A provider who is granted a variance to admit three (3) or four (4) residents must conduct fire drills as described in Section 600 of these rules, except the frequency of the fire drills must be at least monthly. ( )

141. -- 149. (RESERVED)

150. INSPECTIONS OF HOMES.
The Department will inspect each certified family home~~s~~ at least every twenty-four (24) months~~, beginning with~~ calculated from the first month of the most recent certification. Inspections may occur more frequently as the Department deems necessary. The Department may consider the results of previous inspections, history of compliance with rules, and complaints to determine the frequency of inspections. ~~(4-11-06)~~( )

01. Notice of Inspection. All inspections ~~and investigations~~, except for the initial certification study, may be made unannounced and without prior notice. ~~(4-11-06)~~( )

02. Inspection by Department or ~~Its~~ Certifying Agent. The Department may use the services of any ~~legally~~ qualified person or organization, either public or private, to examine and inspect any home requesting certification. The inspector has the authority to have full access to the home and the authority to: ~~(4-11-06)~~( )

~~03~~**a.** ~~**Access by Inspector**. *An inspector must have full access and authority to e*~~Examine quality of care and service~~s~~ delivery~~.~~;

b. Examine home records, resident records, ~~records including~~ and any records or documents pertaining to any financial transactions between residents and the home, including resident accounts~~.~~; ( )

c. Examine the physical premises, including the condition of the home, grounds and equipment, food service, water supply, sanitation, maintenance, and housekeeping practices~~, and~~; ( )

d. Examine any other areas necessary to determine compliance with these rules and standards~~.~~; ~~(4-11-06)~~( )

~~a~~**e.** ~~*An inspector has the authority to i*~~Interview the provider, any adults living in the home, the resident and the resident's ~~family~~ *relatives*, substitute caregivers, persons who provide incidental supervision, and any other person who is familiar with the home or its operation. Interviews with residents ~~will be~~ are confidential and conducted privately unless otherwise specified by the resident~~.~~; and ~~(4-11-06)~~( )

~~b~~**f.** ~~The inspector has full authority to i~~Inspect the entire home, ~~accompanied by the provider,~~ including the personal living quarters of ~~family~~ members ~~living in the home~~ of the household, to check for inappropriate storage of combustibles, faulty wiring, or other conditions that may have a direct impact on the operation of the ~~certified family~~ home. The provider, substitute caregiver, or any other adult living in the home may accompany the inspector. ~~(4-11-06)~~( )

0~~4~~3. ~~Written Report~~ **Statement of Deficiencies**. ~~Following any~~ When violations of these rules are identified through the course of an investigation or inspection, depending on the severity, the Department ~~will provide a written report~~ may send a statement of deficiencies to the provider ~~of the home~~ within thirty (30) days of the completed inspection or investigation. The ~~report~~ statement of deficiencies will include the findings of the investigation or inspection and any rules the home was found to have violated. ~~(4-11-06)~~( )

0~~5~~4. **Plan of Correction**. ~~If~~ When a statement of deficiencies ~~are identified during the investigation or inspection~~ is issued, the ~~home~~ provider ~~will be sent a statement of deficiencies which requires~~ must develop a plan of correction and submit it to the Department for review and approval. ~~(4-11-06)~~( )

a. Depending on the severity of the deficiency, the ~~home~~ provider may be given up to fourteen (14) calendar days to develop a written plan of correction and to return the plan of correction to the ~~Department~~ regional certifying agent where the home is located as listed in Section 005 of these rules. ~~(4-11-06)~~( )

b. An acceptable plan of correction must include: ( )

i. ~~h~~How ~~the~~ each deficiency identified in the statement of deficiencies was corrected or how it will be corrected~~,~~; ( )

ii. ~~w~~What steps have been taken to assure that the deficiency does not recur~~, and~~; ( )

iii. ~~a~~Acceptable time frames for correction of the deficiency~~.~~; and ~~(4-11-06)~~( )

iv. Signature of the provider. ( )

c. Follow-up inspections may be conducted to determine whether corrections to deficiencies are being made according to ~~time frames established in~~ the Department approved plan of correction. ~~(4-11-06)~~( )

d. The Department may provide consulting services to ~~a home~~ the provider, upon request, to assist in identifying and correcting deficiencies and upgrading the quality of care in the home. ~~(4-11-06)~~( )

05. List of Deficiencies. A current list of deficiencies, including plans of correction, are available to the public upon request at the home or by written request to the Department according to Section 006 of these rules. ( )

151. -- 159. (RESERVED)

160. COMPLAINT PROCEDURE.
Any person who believes that any rule in this chapter has been violated by a certified family home may file a complaint with the Department ~~at the address~~ as listed in Section 005 of these rules ~~or at the Department's Regional Office~~. ~~(4-11-06)~~( )

01. Investigation. ( )

a. The Department will investigate any complaint alleging a violation of these rules. Any complaint involving ~~the~~ abuse, neglect, or exploitation of a~~n~~ *vulnerable* adult ~~must~~ will also be referred to adult protective services ~~in accordance with the Adult Abuse, Neglect, and Exploitation Act,~~ according to Section 39-5303, Idaho Code. ~~(4-11-06)~~( )

b. The Department will investigate or cause to be investigated any reported critical incident affecting

health and safety or change in a resident's condition, including the death of a resident, which indicates there was a violation of these rules. ( )

02. Investigation Method. The nature of the complaint will determine the method used to investigate the complaint. On-site investigations at the home ~~may~~ can be unannounced and without prior notice. ~~(4-11-06)~~( )

03. Written Report. Following completion of an investigation, the Department will provide a written report to the provider within thirty (30) days. The report will include the findings of the investigation. ( )

0~~3~~4. Statement of Deficiencies. ~~If~~ When violations of these rules are identified through the course of an investigation, depending on the severity, the Department may send the home a statement of deficiencies *as* described in Section 150 of these rules. *When the Department issues a statement of deficiencies,* ~~T~~the ~~home~~ provider must prepare and submit a plan of correction as described in S~~ubs~~ection 150 of these rules~~, and return it to the Department within the time frame designated by the Department~~. ~~(4-11-06)~~( )

0~~4~~5. Public Disclosure. Information received by the Department through filed reports, inspections, or as otherwise authorized under the law, must not be disclosed publicly in such a manner as to identify individual residents except in a proceeding involving a question of certification. ~~(4-11-06)~~( )

~~**05. List of Deficiencies**. A current list of deficiencies including plans of correction will be available to the public upon request in the individual homes or by written request to the Department.~~ ~~(4-11-06)~~

161. -- 169. (RESERVED)

170. ~~ELEMENTS~~ MINIMUM STANDARDS OF CARE.
~~As a condition of certification, t~~The ~~home~~ provider must ~~provide~~r adequately care for each ~~of the following to the~~ resident ~~without additional charge.~~ as follows: ~~(4-11-06)~~( )

01. Plan of Service. Provide the services required to meet the terms of the resident's plan of service as described in Section 250 of these rules, including development and implementation of the plan of service for private-pay residents and implementation of the plan of service for publicly-funded residents. ( )

0~~1~~2. Supervision. **Provide** ~~A~~appropriate~~,~~ and adequate supervision for twenty-four (24) hours each day ~~unless~~ according to the resident's plan of service ~~provides for alone time~~. ~~(4-11-06)~~( )

0~~2~~3. Daily Living Activities ~~and Recreation~~. ~~Daily activities, recreational activities, maintenance of self help skills, assistance with~~ Provide assistance to the resident at the level of care indicated on the resident's plan of service in the areas of activities of daily living and ~~provisions for trips to social functions, special diets, and arrangements for payments~~ instrumental activities of daily living. ~~(4-11-06)~~( )

~~**03. Medical**. Arrangements for medical and dental services and monitoring of medications. If the resident is unable to give medical consent, the provider will give the name and contact information of the person holding guardianship or power of attorney for health care to any health care provider upon request.~~ ~~(4-11-06)~~

~~**04. Furnishings and Equipment**. Linens, towels, wash cloths, a reasonable supply of soap, shampoo, toilet paper, sanitary napkins or tampons, first aid supplies, shaving supplies, laundering of linens, housekeeping service, maintenance, and basic television in common areas. In addition, the following will apply:~~ ~~(4-11-06)~~

~~**a.** Resident living rooms must contain reading lamps, tables, and comfortable chairs or sofas;~~ ~~(4-11-06)~~

~~**b.** The resident must be provided with his own bed which must be at least thirty six (36) inches wide, substantially constructed, and in good repair. Roll-away type beds, cots, folding beds, or double bunks must not be used. The bed must be provided with springs which are in good repair, a clean and comfortable mattress which is standard for the bed, and a pillow;~~ ~~(4-11-06)~~

~~c. The resident sleeping room must be equipped with a chair and dresser, substantially constructed and in good repair; (4-11-06)~~

~~d. On request, each sleeping room must be equipped with a lockable storage cabinet for personal items for each resident, in addition to the required storage in resident sleeping rooms; (4-11-06)~~

~~e. Adequate and satisfactory equipment and supplies must be provided to serve the residents. The amount and kind will vary according to the size of the home and type of resident; and (4-11-06)~~

~~f. A monitoring or communication system must be provided when necessary due to the size or design of the home. (4-11-06)~~

~~05. Plan of Service. Development and implementation of the plan of service for private pay residents and implementation of the plan of service for state funded residents. (4-11-06)~~

~~06. Activity Supplies. Activity supplies in reasonable amounts, that reflect the interests of the resident. (4-11-06)~~

~~07. Transportation. Arrangement of transportation in reasonable amounts to community, recreational and religious activities within twenty five (25) miles of the home. The home must also arrange for emergency transportation. (4-11-06)~~

04. Medication Management. Provide assistance and monitoring of medications as described in Sections 400 through 402 of these rules, as applicable. ( )

05. Emergency Services. Provide immediate and appropriate interventions on behalf of the resident in response to an emergency, including the following: ( )

a. Developing plans in advance of an emergency as described in Section 600 of these rules and executing those plans when necessary; ( )

b. Evacuating the resident from the home; ( )

c. Providing first aid to the resident when seriously injured; ( )

d. Administering CPR to the resident unless the resident has an order not to resuscitate; ( )

e. Arranging for emergency transportation; and ( )

f. Contacting 9-1-1 for involvement of law enforcement officers or the fire department when necessary for the protection of the resident. ( )

06. Supportive Services. Coordinate paid services for the resident outside the home, including: ( )

a. Medical appointments; ( )

b. Dental appointments; ( )

c. Other services in the community as identified in the plan of service or reasonably requested by the resident; and ( )

d. Arrange transportation to the service location and return to the home. ( )

07. Resident Rights. Protect the resident's rights as listed in Section 200 of these rules. ( )

08. Safe Living Environment. Provide a physical living environment that complies with Sections 500 through 710 of these rules. ( )

171. -- 174. (RESERVED)

174. ACTIVITIES AND COMMUNITY INTEGRATION.
Section 39-3501, Idaho Code, requires that a certified family home provide a homelike, family-styled living environment with a focus on integrated community living. The provider must offer the following: ( )

01. Activities. Recreational activities, provisions for trips to social functions, and daily activities.( )

02. Activity Supplies. Activity supplies in reasonable amounts, that reflect the interests of the resident. ( )

03. Transportation. Arrangement of transportation to and from community, recreational, and religious activities within twenty-five (25) miles of the home when requested by the resident at least twenty-four (24) hours in advance. ( )

175. ROOM, UTILITIES AND MEALS.
The home must provide room, utilities and three (3) daily meals to the resident. The charge for room, utilities and three (3) daily meals must be established in the admission agreement. The following are included in the charge for room, utilities and meals: ~~(4-11-06)~~( )

01. Sleeping Room. The resident sleeping room must meet the requirements of Section 700 of these rules, must be equipped with a dresser, and when requested by the resident a chair, that are both substantially constructed and in good repair. ( )

02. Bed. The resident must be provided with his own bed that is at least thirty-six (36) inches wide, substantially constructed, and in good repair. Roll-away type beds, cots, folding beds, or double bunks must not be used. The bed must have box springs kept in good repair, a clean and comfortable mattress, bedspread, sheets and pillow cases, and pillow that are standard for the size of the bed. ( )

03. Monitoring or Communication System. A monitoring or communication system must be provided when necessary due to the size or design of the home or the needs of the resident. The provider must hold a written agreement with the resident or resident's representative prior to using a monitoring system that may violate the resident's right to privacy. ( )

04. Secure Storage. On request, each sleeping room must be equipped with a lockable storage cabinet *or drawer* for personal items for each resident, in addition to the required storage in resident sleeping rooms. ( )

05. Bathroom. Access to bathing and toilet facilities that meet the requirements of Section 700 of these rules. ( )

06. Common Areas. Access to a common living area that contains reading lamps, tables, comfortable chairs or sofas, and basic television. The resident must be allowed to eat with the other members of the household if he so chooses. ( )

07. Supplies. Bath and hand towels; wash cloths; a reasonable supply of soap, shampoo, toilet paper, and facial tissue; and first aid supplies. ( )

08. Housekeeping Service. Housekeeping and maintenance as required in Section 500 of these rules, including laundering of linens and clothing. ( )

09. Water. Potable water that meets the requirements of Section 500 of these rules. ( )

10. Sewer. A sewage disposal system that meets the requirements of Section 500 of these rules. ( )

11. Trash. Disposal of garbage that meets the requirement of Section 500 of these rules. ( )

12. Heating and Cooling. Sufficient heating and cooling to meet the requirements of Section 700 of these rules. ( )

13. Electricity. Sufficient electricity to power common household and personal devices. ( )

14. Telephone. Access to a telephone that meets the requirements of Section 700 of these rules. ( )

15. Meals. The provider must offer breakfast, lunch, and dinner to the resident. ( )

a. Food must be prepared in safe and sanitary methods that conserve nutritional value, flavor and appearance, when prepared by the provider or other member of the household. ( )

b. Meals offered by the home must meet the dietary requirements or restrictions of the resident when so ordered by a health care professional. ( )

176. -- 179. (RESERVED)

180. HOURLY ADULT CARE.
Hourly adult care, also referred to as adult day health, is a supervised, structured, paid service that may be provided in the home for up to fourteen (14) hours in any twenty-four (24) hour period to adult participants who are not residents of the home. Hourly adult care encompasses health and social services, recreation, supervision, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. The standards in this section do not apply if the service does not include a payment component to the provider, or the hourly adult care participant is a relative of the provider whose care is not publicly funded. Hourly adult care may be offered in the home when the following requirements are met: ( )

01. Participants. No individual will be admitted to the home for hourly adult care who requires ongoing skilled nursing care or for whom the provider cannot adequately provide services and supervision. ( )

02. Records. All records of services delivered by the provider must be maintained in the home for at least five (5) years from the date of service. ( )

03. Enrollment Contract. The provider maintains an enrollment contract with each hourly adult care participant that contains the following: ( )

a. Full name of the participant; ( )

b. The participant's date of birth; ( )

c. Primary address of the participant; ( )

d. Names and telephone numbers of the participant's responsible party and other emergency contacts; ( )

e. Name and telephone number of the participant's primary physician; ( )

f. List of medications, diets, allergies, services, and treatments prescribed for the participant and other pertinent health information regarding the participant's needs; ( )

g. Services the provider must provide to the participant while in the home, which may include: activities, meals, supervision, assistance with medications, and assistance with activities of daily living, and the level of care required for each service; ( )

h. The rate charged by the provider for hourly adult care services if the participant is private pay; ( )

i. The number of days the provider will give written notice to the participant's primary contact in

advance of terminating the enrollment contract; ( )

j. The date on which hourly adult day services will commence; and ( )

k. The printed name, signature, and contact information of the individual who completed the enrollment contract and the provider's printed name, signature, and contact information. Upon entering into the contract, a copy of the enrollment information must be provided to each party. ( )

04. Service Logs. Service logs that identify, on a per day basis when hourly adult care services are provided in the home, the name of each participant who received services, the times of arrival to and departure from the home for each participant, and the names of staff who provided services and their arrival and departure times. ( )

05. Space and Accommodations. The provider must only accept hourly adult care participants for whom the home can provide reasonable accommodations. The home must provide the following for hourly adult care participants: ( )

a. Seating on cushioned chairs or sofas positioned at least thirty-two (32) inches apart in common living areas such that all residents and participants in the home may comfortably enjoy the space; ( )

b. A rest area away from the common living areas to permit privacy and to isolate participants who become ill or require rest and is equipped with furniture for napping, such as a bed, lounge chair, couch, or recliner; ( )

c. Access to a bathroom that meets the requirements of Section 700 of these rules; and ( )

d. When caring for participants with physical or sensory impairments, a physical environment that meets the requirements of Section 700 of these rules, as applicable. ( )

06. Resident's Personal Space. The personal living space of the resident, including his sleeping room and on-suite bathroom, if equipped, must not be used by hourly adult care participants at any time. ( )

07. Staffing. The provider must only accept hourly adult care participants for whom he can safely provide the level and types of service required. The provider must ensure that all staff providing hourly adult care services have been sufficiently trained in and follow universal infection control precautions and each participant's specific care plan as documented in the enrollment contract. In addition: ( )

a. Each caregiver providing hourly adult care services must meet the qualifications of a substitute caregiver as described under Section 300 of these rules. ( )

b. The provider must employ sufficient staff to assure safe and proper care for both residents and hourly adult care participants. Staffing must be based on: ( )

i. The functional and cognitive status of each hourly adult care participant and resident; ( )

ii. The size and layout of the home; and ( )

iii. Staffing ratios must not fall below one (1) caregiver to four (4) residents and hourly adult care participants, combined. ( )

08. Medications. Assistance with medications to hourly adult care participants must meet the requirements in Sections 400 through 402 of these rules. ( )

a. The provider is responsible for safeguarding the participant's medications while the participant is receiving services at the home. ( )

b. The participant's medications must not be stored at the home during hours in which the participant

is not receiving hourly adult care services at the home. ( )

09. Fire and Life Safety. The provider must ensure the home adheres to fire and life safety standards described in Section 600 of these rules. For fire and life safety purposes, the hourly adult care participant is *considered* a "resident" when that term is used in Section 600 of these rules. When offering hourly adult care, the provider must: ( )

a. Prohibit smoking or unsupervised smoking in accordance with Section 600 of these rules. ( )

b. Review emergency preparedness plans as required under Section 600 of these rules with the individual who completed the enrollment contract and provide a written copy of the plans to that individual. ( )

c. Conduct fire drills as required in Section 600 of these rules, except that the frequency of the drills must be at least monthly. ( )

181. -- 199. (RESERVED)

200. RESIDENT RIGHTS POLICY.
~~*Each certified family home will develop and implement a written resident rights policy which will*~~ The provider must possess, annually review, and implement a written policy designed to protect and promote the rights of each resident as provided in this section. The written ~~*description of legal*~~ resident rights policy must include ~~*a description of the protection of personal funds and*~~ a statement that ~~*a*~~ the resident or any other individual may file a complaint with the Department ~~*at the address*~~ as described in Section ~~*005*~~ 160 of these rules, ~~*or local Regional Office regarding resident abuse and neglect and misappropriation of resident property in the home*~~ when he believes that any resident's right has been violated. Resident rights policies must include the following: ~~*(4-11-06)*~~( )

01. Privacy. Each resident must be assured the right to privacy with regard to accommodations, medical and other treatment, written and telephone communications, visits and meetings of family and resident groups, including: (4-11-06)

a. The right to send and receive mail unopened, either by postal service, electronically, or by other means, unless the resident's plan of service specifically calls for the provider to monitor the correspondence in order to protect the resident from abuse or exploitation; ~~*(4-11-06)*~~( )

b. If the resident is married, privacy for visits by his spouse. If both are residents in the home, they are permitted to share a room unless medically inadvisable, as documented by the ~~*attending physician*~~ resident's health care professional~~.~~; ~~*(4-11-06)*~~( )

c. The right to control the use of pictures and videos containing the resident's image. ( )

02. Humane Care. Each resident has the right to humane care and a humane environment, including the following: (4-11-06)

a. The right to a diet which is consistent with any religious or health-related restrictions; (4-11-06)

b. The right to refuse a restricted diet;~~ *and*~~ ~~*(4-11-06)*~~( )

c. The right to a safe and sanitary living environment~~.~~; and ~~*(4-11-06)*~~( )

d. The right to an environment free of illicit drug use or possession and other criminal activities. ( )

03. Respectful Treatment. Each resident has the right to be treated with dignity and respect, including: (4-11-06)

a. The right to be treated in a courteous manner by the provider and other individuals in the home; ~~*(4-11-06)*~~( )

b. The right to receive a response from the ~~home~~ provider to any request of the resident within a reasonable time; ~~(4-11-06)~~( )

c. Freedom from discrimination on the basis of race, color, national origin, sex, religion, age, disability, or veteran status; ~~and~~ ~~(4-11-06)~~( )

d. Freedom from intimidation, manipulation, and coercion~~, and exploitation~~.; ~~(4-11-06)~~( )

e. The right to wear his own clothing~~.~~; and ~~(4-11-06)~~( )

f. The right to determine his own dress and hair style~~.~~. ~~(4-11-06)~~( )

04. Basic Needs Allowance. Each ~~R~~resident~~s~~ whose care is paid for by publicly-funded assistance must retain, for ~~their~~ his personal use, the difference between ~~their~~ his total monthly income and the Certified Family Home basic allowance established by IDAPA 16.03.05. "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled," Section 513. ~~(4-11-06)~~( )

05. Resident Funds and Property. Each ~~R~~resident~~s~~ ~~have~~ has the right to manage ~~their~~ his personal funds and use his personal property. ( )

a. ~~A home~~ The provider must not require ~~a~~ the resident to deposit his personal funds ~~with the home~~ into an account controlled by any other person. ~~(4-11-06)~~( )

b. Upon *accepting* written authorization from the resident, or the resident's representative, *allowing* the provider, provider's relative, *or other member of the provider's household* to manage the resident's personal funds, the provider must hold, safeguard, and account for the resident's personal funds as required in Section 275 of these rules. ( )

c. The resident has the right to retain and use his own personal property in his own living area in order to maintain his individuality and personal dignity. The storage and use of these items by the resident must not present a fire or life safety hazard. ( )

06. Access to Resident. Each ~~home~~ provider and individuals living in the home must permit immediate access to any resident by any representative of the Department, by the state ~~O~~ombudsman for the elderly or his designee~~s~~, by an adult protection investigator or by the resident's personal ~~physician~~ health care professional. Each home must also permit the following: ~~(4-11-06)~~( )

a. Immediate access to a resident by ~~immediate family or other~~ his relatives, subject to the resident's right to deny or withdraw consent at any time; ~~(4-11-06)~~( )

b. Immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time; (4-11-06)

c. Reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time~~.~~; and ~~(4-11-06)~~( )

d. Reasonable access to the resident's records, medications and treatments by the resident's health care professional subject to the resident's permission. ( )

07. Freedom From Harm.The resident has the right to be free from: ( )

a. ~~p~~Physical, mental, or sexual abuse~~,~~; ( )

b ~~n~~Neglect~~,~~; ( )

c. Exploitation; ( )

d. ~~c~~Corporal punishment~~.~~; ( )

e. ~~i~~Involuntary seclusion~~.~~; and ( )

f. ~~a~~Any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat a medical condition. ~~(4-11-06)~~( )

~~***a.*** *A certified family provider who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, or exploited must immediately report this information to the Idaho Commission on Aging or its Area Agencies on Aging, according to Section 39-5303, Idaho Code.* (4-11-06)~~

~~***b.*** *The home must report within four (4) hours to the appropriate law enforcement agency when there is reasonable cause to believe that abuse, neglect, misappropriation of resident's property, or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult resident according to Sections 39-5303 and 39-5310, Idaho Code.* (4-11-06)~~

08. Health Services. The resident has the right to control his health-related services, including: (4-11-06)

a. The right to retain the services of his own personal physician and dentist; (4-11-06)

b. The right to select the pharmacy or pharmacist of his choice; (4-11-06)

c. The right to confidentiality and privacy concerning his medical or dental condition and treatment; (4-11-06)

d. The right to participate in the formulation of his plan of service~~.~~; ~~(4-11-06)~~( )

e. The right to decline treatment for any medical condition; and ( )

f. When the resident is unable to give medical consent, the provider will give the name and contact information of the person holding guardianship or power of attorney for health care to any health care provider upon request. ( )

09. Grievance. ( )

a. The resident has the right to voice or file a grievance with respect to care or service that is ~~(~~or fails to be~~)~~ furnished, without discrimination or reprisal for voicing the grievance and the right to prompt efforts by the ~~*home*~~ provider to resolve grievances the resident may have, including those with respect to the behavior of other residents. ~~(4-11-06)~~( )

b. The provider must provide a written response to the resident or resident's representative describing how he resolved or attempted to resolve the grievance, and maintain a copy of this written response in the resident record. ( )

10. Advance Notice. The resident must receive written advance notice at least thirty (30) calendar days prior to his non-emergency transfer or discharge unless the transfer or discharge is for a reason described in Section 260, including the following: ( )

a. The resident is transferred or discharged only for medical reasons~~, or for~~; ( )

b. To protect his welfare or the welfare of other ~~*residents, or for*~~ members of the household; ( )

c. ~~n~~Nonpayment for his stay~~.~~; ~~(7-1-17)~~( )

d. The resident violates any condition mutually established between the resident and the provider at the time of admission; or ( )

e. The resident engages in unlawful delivery, production, or use of a controlled substance on the premises of the home. ( )

11. Other Rights. In addition to the rights outlined in Subsections 200.01 through 200.10 of ~~these~~ this rule~~s~~, the resident has the following rights: (4-11-06)

a. The resident has the right to refuse to perform services for the home except as contracted between the resident and the provider. The provider agrees to pay the resident for such services, and the provider pays the resident a wage consistent with state and federal law; ~~(4-11-06)~~( )

b. The resident must have access to his personal records, including those described in Section 270 of these rules, and must have the right to confidentiality of personal, medical, and clinical records; ~~(4-11-06)~~( )

c. The resident has the right to practice the religion of his choice or to abstain from religious practice. Residents must also be free from the imposition of the religious practices of others; (4-11-06)

d. The resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the home; (4-11-06)

e. The resident has the right to examine, upon reasonable request, the results of the most recent inspection of the home conducted by the Department with respect to the home and any plan of correction in effect with respect to the home; (4-11-06)

f. The resident has ~~a~~ the right to review a list of other certified family homes that may be available to meet his needs in case of transfer; ~~(4-11-06)~~( )

g. The resident has the right ~~not to be required to receive~~ to refuse routine care of a personal nature from ~~a member of the opposite sex~~ *any person whom the resident is uncomfortable receiving such care*; ~~(4-11-06)~~( )

h. The resident has the right to be informed, in writing, regarding the formulation of advance directives as described in Title 39, Chapter 45, Idaho Code; and (4-11-06)

i. The resident must have any other right established by law. (4-11-06)

201. NOTICE OF ~~LEGAL~~ RESIDENT RIGHTS.

01. Resident Rights Notice. The c~~ertified family home will~~ provider must inform the resident or his representative, verbally and in writing, at the time of admission to the home, of his legal rights during the stay at the home *acknowledged by* date and signature*s*. These rights are found in Section 200 of these rules. *The provider must supply a copy of the resident rights policy to the resident or the resident's representative.* ~~(4-11-06)~~( )

02. Annual Review of Resident Rights. The provider must review the resident rights policy with the resident or his representative at least annually including date and signature. ( )

03. Documentation of Review. The provider must retain the signed and dated copy of the policy in the resident's record indicating that the resident or resident's representative has had the opportunity to review the policy. ( )

202. ACCESS BY ADVOCATES AND REPRESENTATIVES.

~~A certified family home~~ The provider, substitute caregivers and adult members of the household must permit advocates and representatives of community and legal services programs, whose purposes include rendering assistance without charge to residents, to have access to the home at reasonable times. Advocates and representatives may observe all common areas of the home. Access must be permitted in order for advocates and representatives to

provide the following-: ~~(4-11-06)~~( )

01. Inform Residents of Services. Visit, talk with and make personal, social ~~service programs~~ and legal services available to all residents. ~~(4-11-06)~~( )

02. Inform Residents of Rights. Inform residents of their rights and entitlements, their corresponding obligations under state, federal, and local laws by distribution of educational materials or discussion in groups and with individuals. (4-11-06)

03. Assist Residents to Secure Rights. Assist residents in asserting their legal rights regarding claims for public assistance, medical assistance, and social security benefits, as well as in other matters in which residents are aggrieved. This assistance may be provided individually or in a group basis, and may include organizational activity, counseling, and litigation. (4-11-06)

04. Advise and Represent. Engage in other methods of assisting, advising, and representing residents so as to extend to them the full enjoyment of their rights. (4-11-06)

05. Communicate Privately. Communicate privately and without restrictions with any resident who consents to the communication. (4-11-06)

203. -- 2~~2~~409. (RESERVED)

210. REPORTING REQUIREMENTS.
The provider must report to the regional certifying agent where the home is located as listed in Section 005 of these rules or appropriate agency or individual for the following: ( )

01. Serious Physical Injury or Death. The provider must report to the appropriate law enforcement agency within four (4) hours when there is reasonable cause to believe that abuse, neglect, or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a resident according to Sections 39-5303 and 39-5310, Idaho Code. ( )

02. Abuse, Neglect, or Exploitation. When the provider has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected, or exploited, he must immediately report this information to the Idaho Commission on Aging or its Area Agencies on Aging, according to Section 39-5303, Idaho Code. ( )

03. Critical Incidents. The provider must notify the certifying agent when a critical incident affects the health or safety of the resident or leads to a change in the resident's condition, including serious illness, accident, elopement, death, or adult protective services or law enforcement contact and investigation. Reporting requirements are as follows: ( )

a. Within twenty-four (24) hours of the resident's death or disappearance; and ( )

b. Within three (3) business days following: ( )

i. Contact from adult protective services or law enforcement in conjunction with an investigation; ( )

ii. A visit to an urgent care clinic or emergency room; or ( )

iii. Admission to a hospital. ( )

04. Report of Fire. A separate report on each fire incident occurring within the home, for which a fire extinguisher was discharged or 9-1-1 was contacted, must be submitted to the certifying agent within three (3) business days of the occurrence. The report must include: ( )

a. Date of the incident; ( )

b. Origin of the fire; ( )

c. Extent of damage; ( )

d. How *and by whom* the fire was extinguished; and ( )

e. Injuries *or deaths*, if any. ( )

05. Additional Criminal Convictions. The provider must immediately report any additional criminal convictions for himself, any other adult living in the home or a substitute caregiver to the certifying agent. ( )

06. Notice of Investigations. The provider must immediately report *to the certifying agent* when he, any other adult living in the home, or a substitute caregiver is charged with or under investigation *by law enforcement, adult protection services, or child protection services* for: ( )

a. *A*buse, neglect, or exploitation of any vulnerable adult or child; ( )

b. *Other* criminal *conduct;* or ( )

c. *W*hen an adult protection or child protection complaint is substantiated. ( )

07. Reporting of Funds Managed by the Provider for a Deceased Resident. For funds managed under Section 275 of these rules, the following is required: ( )

a. On the death of a private-pay resident, the provider must convey the resident's funds, with a final accounting of those funds, to the individual administering the resident's estate within thirty (30) days. ( )

b. On the death of a publicly funded resident, the provider must convey the resident's funds, with a final accounting of those funds, to the Department within thirty (30) days. ( )

08. Discharge of a Resident*. The provider must immediately notify the certifying agent upon the discharge of any resident from the home.* ( )

2~~03~~11. -- 224. (RESERVED)

225. UNIFORM ASSESSMENT REQUIREMENTS.

01. State Responsibility for ~~State~~ Publicly - Funded Residents. The Department will assess ~~*State-funded*~~ residents accessing services through a publicly funded program according to ~~*IDAPA 16.03.23, "Rules Governing Uniform Assessments for State Funded Clients."*~~ uniform criteria developed to assess all participants within that respective program. Assessment criteria may vary from one program to another, but must be uniform within the same program. ~~*(4-11-06)*~~( )

02. Provider Responsibility for Private-Pay Residents. The provider will develop, identify, assess, or direct a uniform needs assessment of each private-pay resident~~s~~. ~~*The Department's Uniform Assessment Instrument may be used as the uniform needs assessment as described in IDAPA 16.03.23, "Rules Governing Uniform Assessments for State-Funded Clients."*~~ The uniform needs assessment: ~~*(4-11-06)*~~( )

a. Must be completed no later than fourteen (14) calendar days after admission; ( )

b. Must be reviewed when there is a change in *condition*, or every twelve (12) months, whichever occurs first; ( )

c. Must include: ( )

i. Identification and background information; ( )

ii. Medical diagnosis; ( )

iii. Medical and health needs; ( )

iv. Prescriptions, including route of administration, and all over-the-counter medications, supplements, treatments, and special diets, if applicable; ( )

v. Historical and current behavior patterns; ( )

vi. Cognitive function; ( )

vii. Psychosocial and physical needs of the resident; ( )

viii. Functional status; ( )

ix. Assessed level of care; and ( )

x. A statement from the resident's health care professional indicating the resident is appropriate for certified family home care. ( )

d. May be the Department's Uniform Assessment Instrument (UAI) as described in IDAPA 16.03.23, "Rules Governing Uniform Assessments for State-Funded Clients," for a private-pay resident's uniform needs assessment. Upon request by the provider, the Department will provide training in conducting uniform needs assessments. ( )

03. Results of Assessment. The results of the assessment ~~*may be*~~ for both publicly funded and private-pay residents *are* used to evaluate the ability of ~~*a*~~ the provider to meet the identified resident's needs. The results of the assessment may also be used to determine the need for special training or licenses or certificates that may be required to care for certain residents. ~~*(4-11-06)*~~( )

~~***04. Uniform Needs Assessment for Private Pay**. The uniform needs assessment used by the home for private-pay residents must include:* *(4-11-06)*~~

~~***a.** Identification and background information;* *(4-11-06)*~~

~~***b.** Medical diagnosis;* *(4-11-06)*~~

~~***c.** Medical and health problems;* *(4-11-06)*~~

~~***d.** Prescription and over the counter medications;* *(4-11-06)*~~

~~***e.** Behavior patterns;* *(4-11-06)*~~

~~***f.** Cognitive function;* *(4-11-06)*~~

~~***g.** The psychosocial and physical needs of the resident;* *(4-11-06)*~~

~~***h.** Functional status; and* *(4-11-06)*~~

~~***i.** Assessed level of care.* *(4-11-06)*~~

~~***05. Time Frames for Completing the Uniform Needs Assessment for Private Pay Residents**. The assessment must be completed no later than fourteen (14) calendar days after admission. The assessment must be reviewed when there is a change in need, or every twelve (12) months, whichever comes first. Upon request, the Department may provide training in conducting a uniform needs assessment.* *(4-11-06)*~~

226. -- 249. (RESERVED)

250. PLAN OF SERVICE.
The resident must have a plan of service. The plan must identify the resident, describe the services to be provided, and describe how the services will be delivered. (4-11-06)

01. Core Elements. A resident's plan of service ~~will~~ must be based on the orders of the resident's health care professionals, and: ~~(4-11-06)~~( )

a. Assessment; (4-11-06)

b. Service needs for activities of daily living; (4-11-06)

c. Need for limited nursing services; (4-11-06)

d. Need for medication assistance; (4-11-06)

e. Frequency of needed services; (4-11-06)

f. Level of ~~assistance~~ care; ~~(4-11-06)~~( )

g. Habilitation and training needs; (4-11-06)

h. Behavioral management needs, including identification of situations that trigger inappropriate behavior; (4-11-06)

i. ~~Physician's d~~Dated history and physical *from the resident's health care professional reflecting the resident's current health status and conducted no earlier than twelve (12) months prior to admission*;~~(4-11-06)~~( )

j. Admission records; (4-11-06)

k. Community supportive ~~systems~~ services; ~~(4-11-06)~~( )

l. Resident's desires; (4-11-06)

m. Resident's need for supervision, including the degree; ( )

~~m~~**n.** Transfer and discharge requirement; and (4-11-06)

~~n~~**o.** Other identified needs. (4-11-06)

02. Signature and Approval. The provider and the resident~~, his legal guardian or his conservator~~ or the resident's representative must sign and date the plan of service upon its completion, within fourteen (14) days after the resident's admission. ~~For homes serving state-funded residents, services must be authorized by the Department prior to admission.~~ ~~(4-11-06)~~( )

03. Developing the Plan. The provider will consult the resident and other individuals identified by the resident in developing the plan of service. Professional staff must be involved in developing the plan if required by another program. (4-11-06)

04. Resident Choice. A resident must be given the choice and control of how and what services the provider or external vendors will provide to the extent the resident can make choices. (4-11-06)

05. Copy of the Plan. Signed copies of the plan of service must be placed in the resident's file, given to the resident, and given to his l~~egal guardian or his conservator~~ representative, if applicable, no later than fourteen (14) days after admission. ~~A~~ For a resident receiving services through a publicly-funded program, the copy of the ~~Department approved~~ plan must ~~be in the resident's file, if applicable~~ indicate that it has been approved by the

Department. ~~(4-11-06)~~( )

06. Changes to the Plan. A record must be made of any changes to the plan or when the provider is unable to provide services outlined in the plan of service. *When changes to the plan are made, the resident or resident's representative and the provider must sign and date the changes.* ~~(4-11-06)~~( )

07. Periodic Review. The next scheduled date of review must be documented in the plan of service. The plan of service should be reviewed as necessary but must be reviewed at least every twelve (12) months.
(4-11-06)

251. - 259. (RESERVED)

260. ADMISSIONS.
According to Section 39-3507, Idaho Code, the provider must only admit or retain residents in the home for whom he has the training, appropriate skills, and time to provide adequate care. The provider must be able to provide the levels of service or types of service required for each resident admitted to the home. ( )

01. Prior Approval Required. The provider must obtain approval from the Department for each *admission* prior to the *prospective* resident moving into the home. The following must be provided to the regional certifying agent where the home is located as listed in Section 005 of these rules to aid the Department in making its determination: ( )

a. Name, gender and date of birth of the prospective resident; ( )

b. The contemplated date of admittance of the prospective resident into the home; ( )

c. The prospective resident's history and physical from his health care professional, conducted within the previous twelve (12) month period reflecting his current health status; ( )

d. A list of the resident's current medications and treatments from his health care professional; ( )

e. Contact information for the resident's health care professionals; ( )

f. Contact information for the prospective resident's representative, if applicable; ( )

g. The resident's plan of service from another health care setting, or any such plan of service conducted for the resident within the previous six (6) months, if one exists, when the resident transfers to the home from another health care setting; and ( )

h. Other information requested by the Department relevant to the appropriateness of the admission and the provider's ability to provide adequate care. ( )

02. Notification. Within five (5) business days of receipt of the documents listed in Subsection 260.01 of this rule, the Department will notify the provider verbally or in writing whether the proposed admission is approved or denied. When verbal notification is given, the Department will provide follow-up written communication to the provider stating the approval or denial within ten (10) business days. ( )

03. Emergency Admission. The provider may not accept an emergency admission without prior approval from the Department except under the following conditions: ( )

a. The provider may make a conditional admission when he reasonably believes he has the ability to provide adequate care to the resident when the request for an emergency placement occurs after normal business hours and the provider is unable to contact the Department for prior approval. The provider must notify the resident or his representative that the admission is conditional upon Department approval. ( )

b. The provider must notify the regional certifying agent where the home is located as listed in

Section 005 of these rules the next business day after making a conditional admission. ( )

c. The provider must follow the regular admission process described in Subsection 260.01 of this rule within two (2) business days of making a conditional admission. The Department may deny the placement and require the resident to transfer when there is reasonable cause to believe the provider lacks the ability to provide adequate care. ( )

0~~1~~4. Admission Agreement. At the time of admission to a certified family home, the provider and the resident or resident's representative, if applicable, must enter into an admission agreement. The agreement ~~*will*~~ must be in writing and must be signed and dated by both parties. The agreement must, in itself or by reference to the resident's plan of ~~*care*~~ service, include at least the following: ~~*(4-11-06)*~~( )

a. Whether or not the resident will assume responsibility for his own medication ~~*including reporting missed medication or medication taken on a PRN basis*~~; ~~*(4-11-06)*~~( )

b. ~~*Whether or not the resident has ongoing ability to safeguard himself against personal harm, injury or accident.*~~ The ~~*certified family home*~~ provider must have a plan in place for steps ~~*it*~~ the provider will take if the resident is not able to carry out his own self-preservation. ~~*(4-11-06)*~~( )

c. Whether or not the provider will accept responsibility for the resident's funds; (4-11-06)

d. How a partial month's refund will be managed; (4-11-06)

e. Responsibility for valuables belonging to the resident and provision for the return of a resident's valuables should the resident leave the home; (4-11-06)

f. Amount of liability coverage provided by the homeowner's or renter's insurance policy~~.~~ and whether the insurance policy covers the resident's personal belongings; ~~*(4-11-06)*~~( )

g. Written notice of at least thirty (30) calendar days as agreed to in the admission agreement prior to discharge on the part of either party or transfer ~~*or discharge on the part of either party;*~~, when the transfer is not for medical reasons or for the resident's welfare or the welfare of others, or when the discharge is not for a situation described in Subsection 260.05.b. of this rule; ~~*(7-1-17)*~~( )

h. Conditions under which an emergency ~~*transfers*~~ temporary placement will be made as described under Subsection 260.06 of this rule; ~~*(4-11-06)*~~( )

i. Signed permission to ~~*transfer*~~ provide pertinent information from the resident's record to a hospital, nursing home, residential and assisted living facility, or other certified family home; ~~*(4-11-06)*~~( )

j. Responsibility to obtain consent for medical procedures including the name, address, and telephone number of *the* guardian or power of attorney for health care for any resident who is unable to make his own medical decisions~~.~~; ~~*(4-11-06)*~~( )

k. Resident responsibilities as appropriate; (4-11-06)

l. Amount the ~~*home*~~ provider will charge the resident for room, utilities and three (3) daily meals on a monthly basis, and if the resident is private-pay or has a share of cost, a separately listed amount the provider will charge for care on a monthly basis; ~~*and*~~ ~~*(4-11-06)*~~( )

m. Written notice of at least fifteen (15) calendar days as agreed to in the admission agreement prior to the provider changing the charges to the resident as described in Subsection 260.04.l. of this rule; ( )

n. Protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. The admission agreement must either: ( )

i. Adopt the eviction and appeal processes as described in Title 6, Chapter 3, Idaho Code; or ( )

ii. Adopt the eviction and appeal processes as described in the version of the admission agreement provided by the Department; and ( )

~~m~~o. ~~Other information as needed.~~ Additional conditions as agreed upon by both parties but consistent with the requirements of these rules. ~~(4-11-06)~~( )

0~~2~~5. **Termination of Admission Agreement**. The admission agreement must ~~not~~ only be terminated ~~except~~ under the following conditions: ~~(4-11-06)~~( )

a. ~~Giving~~ The provider or the resident, or the resident's representative, if applicable, provides the other party at least thirty (30) calendar days' written notice as agreed to in the admission agreement ~~for any reason~~; or ~~(7-1-17)~~( )

b. ~~The resident's mental or physical condition deteriorates to a level requiring evaluation or services that cannot be provided in a certified family home;~~ A three (3) day written notice may be given by the provider to the resident or the resident's representative, if applicable, when any of the following occur, subject to the appeal process required under Subsection 260.04.n. of this rule: ~~(4-11-06)~~( )

~~c~~i. Nonpayment of the resident's bill identified in Subsection 260.04.l. of this rule; ~~(4-11-06)~~( )

~~d. Emergency conditions requiring a resident to transfer out of the home without thirty (30) calendar days' written notice to protect the resident or other residents in the home from harm; and~~ ~~(7-1-17)~~

~~e~~ii. ~~Other~~ The resident violates written conditions as mutually established between the resident and the provider at the time of admission.; or ~~(4-11-06)~~( )

iii. The resident engages in the unlawful delivery, production, or use of a controlled substance on the premises of the home. ( )

06. Emergency Temporary Placement. The admission agreement will remain in force and effect, excluding the provider's responsibility for care and the charge to the resident for such care as identified in Subsection 260.04.l. of this rule, while the resident is temporarily transferred from the home to another care setting on an emergency basis unless either party terminates the agreement as described in Subsection 260.05 of this rule. *An* emergency temporary placement *must only occur when*: ( )

a. The resident's mental or physical condition deteriorates to a level requiring evaluation or services that cannot be met by the provider or reasonably accommodated by the home; or ( )

b. Emergency conditions requiring the resident to transfer out of the home without thirty (30) calendar days' written notice to protect the resident or other residents, the provider, or other individuals living in the home from harm. ( )

07. Discharge Procedure. The provider must immediately notify the *Department* upon the transfer or discharge of the resident *according to Section 210 these rules*. ( )

08. Return of Resident's Possessions. The provider must document the return of the *resident's personal possessions* to the resident or resident's representative as agreed in the admission agreement according to Subsection 260.04.e. of this rule: ( )

a. *Return immediately upon discharge:* ( )

i. All personal funds belonging to the resident*; and* ( )

ii. Any medication, supplement, or treatment belonging to the resident; ( )

b. *Return within three (3) business days:* ( )

i. If the provider, his relative, or any other member of the household was managing the resident's funds, a *copy of the* final accounting of *the resident's funds*; ( )

ii. All resident belongings as indicated on his belongings inventory; and ( )

iii. Any other item*s* belonging *solely* to the resident, including personal documents. ( )

261. -- 269. (RESERVED)

270. RESIDENT RECORDS.
The provider must maintain records for each resident admitted to the home as provided in this rule. ( )

01. Admission Records. Records required for admission to ~~a~~ the home must be maintained, ~~and~~ updated, and ~~must be~~ kept confidential. The~~ir~~ availability of the records without the consent of the resident, subject to IDAPA 16.05.01, "Use and Disclosure of Department Records," is limited to the ~~home, professional consultants~~ resident and resident's representative, the provider, substitute caregivers, the resident's ~~physician~~ health care professionals, and representatives of the Department including certifying agents. All entries must be ~~kept current,~~ accurate and reflect updated information as changes occur, recorded legibly in ink, ~~dated,~~ signed and dated, and must include: ~~(4-11-06)~~( )

a. The resident's full *legal* ~~N~~name; ~~(4-11-06)~~( )

b. The resident's ~~P~~permanent address if other than the home; ~~(4-11-06)~~( )

c. The resident's ~~M~~marital status and sex; ~~(4-11-06)~~( )

d. The resident's ~~Birth~~ place and date of birth; ~~(4-11-06)~~( )

e. The name, address, and telephone number of an individual identified by the resident or the resident's representative who should be contacted in the event of an emergency or death of the resident; ~~(4-11-06)~~( )

f. The resident's ~~P~~personal ~~physician and dentist~~ health care professionals; ~~(4-11-06)~~( )

g. Admission date and name of the person who completed the admission form; ~~(4-11-06)~~( )

h. Results of a history and physical examination performed by a ~~licensed physician or nurse practitioner within six (6)~~ health care professional reflecting the resident's current health status and conducted no earlier than twelve (12) months prior to admission; ~~(4-11-06)~~( )

~~**i.** For private pay residents, the history and physical should include a description of the resident's needs for personal assistance and supervision, and indicate that the resident is appropriate for placement in a home; (4-11-06)~~

~~**j**~~**i.** A list of medications, treatments, and special diets, if any, prescribed for the resident and signed and dated by ~~the physician~~ his health care professional; ~~(4-11-06)~~( )

~~**k**~~**j.** Religious affiliation if the resident so chooses to disclose; ~~(4-11-06)~~( )

~~**l.** Interested relatives and friends other than those outlined in Subsection 270.01.e. of these rules, to include names, addresses, and telephone numbers of family members, legal guardian or conservator, or significant others, or all; (4-11-06)~~

~~**m**~~**k.** Social information, obtained by the ~~home~~ provider from the resident~~, family~~ or resident's *relatives*, service coordinator, legal guardian or conservator, or other knowledgeable individuals~~. The information must~~ to include the resident's social history, hobbies, and interests; ~~(4-11-06)~~( )

~~n~~**l.** The ~~W~~written admission agreement ~~which is signed and dated by the provider and the resident, his legal guardian or his conservator~~ as described in Section 260 of these rules; ~~(4-11-06)~~( )

~~o~~**m.** A signed copy of the resident~~'s~~ rights policy as ~~specified~~ described in Section 200 of these rules~~, or documentation that the resident, his legal guardian, or his conservator has read and understands his rights as a resident of the home~~; ~~(4-11-06)~~( )

~~p~~**n.** A copy of the resident's ~~most current uniform needs~~ assessment ~~for the certified family home~~ as decribed in Section 225 of these rules; ~~(4-11-06)~~( )

~~q~~**o.** A copy of the *resident's* signed and dated ~~admission~~ plan of service ~~that contains all elements of a plan of service between the resident, his legal guardian, or his conservator and the home~~ as described in Section 250 of these rules; ~~(4-11-06)~~( )

~~r~~**p.** An inventory of the resident's belongings that may consist of photographs or a written descriptive list. The resident ~~can~~ or the resident's representative may inventory any ~~item~~ personal possession he so chooses and expects returned upon the resident's transfer or discharge from the home. The belongings inventory may be updated at any time but must be updated at least annually; ~~(4-11-06)~~( )

~~s~~**q.** Information about any specific health problems of the resident ~~which~~ that may be useful in a medical emergency; ~~and~~ ~~(4-11-06)~~( )

~~t~~**r.** Any other health-related, emergency, or pertinent information ~~which~~ that the resident requests the ~~home~~ provider to keep on record~~.~~; ~~(4-11-06)~~( )

s. If the resident has a representative, a copy of the document giving the representative legal authority to act on behalf of the resident, including guardianship or power of attorney for healthcare decisions; ( )

t. Contact name, address, and telephone number of any individual or agency providing supportive services to the resident; and ( )

u. Signed copy of any care plan that is prepared for the resident by an outside service provider. ( )

02. Ongoing Resident Records. Records must be kept ~~current~~ by the provider for services to the resident showing accurate and updated information as services are rendered, including: ~~(4-11-06)~~( )

~~**a.** Admission information required in Subsection 270.01 of these rules;~~ ~~(4-11-06)~~

~~**b.** A current list of medications, diet, and treatments prescribed for the resident which is signed and dated by the physician giving the order. Current orders may be a copy of the signed doctor's order from the pharmacy;~~ ~~(4-11-06)~~

~~**c.** Documentation of any medication refused by the resident, not given to the resident or not taken by the resident with the reason for the omission. All PRN medication must be documented with the reason for taking the medication;~~ ~~(4-11-06)~~

~~d~~**a.** Any incident or accident occurring while the resident is living in the home~~;~~ and the provider's response. If the incident or accident occurs while the resident is receiving supportive services, the provider must obtain a written report of the event from the service provider; ~~(4-11-06)~~( )

b. The provider's written response to any grievance as described in Section 200 of these rules; ( )

~~e~~**c.** Notes from the licensed nurse, home health agency, physical therap~~y~~ist, ~~and~~ or any other service providers, documenting the services provided to the resident at each visit to the home; ~~(4-11-06)~~( )

~~f~~d. Documentation of significant changes in the resident~~'s~~' physical~~,~~ or mental status,~~ or both~~ and the ~~home's~~ provider's response; ~~(4-11-06)~~( )

~~g~~e. ~~If appropriate~~ When the provider, a relative of the provider, or an individual living in the home other than the resident manages the resident's funds, financial accounting records for such funds as described in Section 275 of these rules; ~~and~~ ~~(4-11-06)~~( )

~~h. The resident's uniform needs assessment, to include the admission assessment and all assessments for the past year, for certified family home care; (4-11-06)~~

~~i. Signed and dated plan of service, to include the admission plan of service and all service agreements for the past year between the resident, his legal guardian, or his conservator and the home; (4-11-06)~~

~~j. Contact name, address, phone number of individuals or agencies providing paid supports; (4-11-06)~~

~~k. Signed copies of all care plans that are prepared by all outside service providers; and (4-11-06)~~

~~l. An inventory of resident's belongings. The resident can inventory any item he chooses. The inventory can be updated at any time but must be updated annually. (4-11-06)~~

f. Medication records as required in Sections 400 through 402 of these rules, as applicable. ( )

03. Maintenance of Resident Records. All records of services delivered by the provider must be maintained in the home for at least five (5) years from the date of service. (4-11-06)

271. -- 274. (RESERVED)

275. RESIDENT FUNDS AND FINANCIAL RECORDS.

01. Resident Funds Policy. ~~If a resident's funds are turned over to the provider for any purpose other than payment for services allowed under these rules, or if the provider or his relative acts as resident payee, the home is deemed to be handling the resident's funds.~~ Each ~~home~~ provider must ~~develop~~ possess and implement a policy and procedure outlining how the resident's funds will be managed. This policy and procedure must include the following: ~~(4-11-06)~~( )

a. Statement of whether the ~~home~~ provider will or will not manage resident funds~~;~~. ~~(4-11-06)~~( )

b. ~~If~~ When ~~the home manages resident funds and~~ the resident leaves the home under any circumstances, the ~~home can~~ provider must: ( )

i. ~~o~~Only retain room and board funds prorated to the last day of the ~~fifteen (15) calendar day notice period, or thirty (30) calendar day~~ notice period as specified in the admission agreement, or upon the resident moving from the home, whichever is later~~.~~; ( )

ii. Immediately return ~~A~~all remaining resident funds ~~must follow~~ to the resident~~,~~ or to the resident's representative as specified in the admission agreement according to Section 260 of these rules; and ~~resident funds must~~ ( )

iii. Only ~~be~~ use~~d~~ the resident's funds for that resident's expenses until a new payee is appointed. ~~(4-11-06)~~( )

c. Prohibit personal loans to the resident from the provider, provider's relatives, and other members of the household unless the loan is from a relative of the resident. When such a loan is made, the provider must: ( )

i. Ensure the terms of the loan are described in a written contract signed by the resident or resident's

representative; *( )*

ii. Maintain a copy of the loan contract in the resident's record; and *( )*

iii. Immediately update documentation of repayments towards the loan. *( )*

02. Managing Resident Funds. *When the resident's funds are turned over to the provider for any purpose other than payment for services allowed under these rules, or if the provider, his relative, or an individual living in the home acts as the resident's payee, the provider is deemed to be managing the resident's funds.* ~~*A home that*~~ The provider who manages a resident's funds must: ~~*(4-11-06)*~~*( )*

a. Establish a separate account at a financial institution for each resident~~. *There can be no commingling of resident funds with home funds. Borrowing between resident accounts is prohibited*~~ to which *use of* the resident's funds may be reconciled by means of a financial statement; ~~*(4-11-06)*~~*( )*

b. Prohibit commingling of the resident's funds with the funds of any other person, including borrowing funds from the resident; *( )*

~~*b*~~**c.** *Upon request,* ~~*N*~~notify the resident ~~*that*~~ *or the resident's representative the amount of the resident's* funds *in his account that* are available for his use; ~~*(4-11-06)*~~*( )*

~~*c*~~**d.** ~~*Bill each*~~ Charge the resident the amount agreed upon in the admission agreement as described in Section 260 of these rules for his certified family home ~~*care charges*~~ services on a monthly basis from his funds; ~~*(4-11-06)*~~*( )*

~~*d*~~**e.** ~~*Document on a monthly or on a weekly basis any*~~ Maintain accounting documentation, including financial statements, receipts and ledgers, for all financial transactions in excess of five dollars ($5) ~~*between the resident and the home*~~ in which the resident's funds were used. A separate transaction record must be maintained for each resident; ~~*(4-11-06)*~~*( )*

~~*e*~~**f.** Restore funds to the resident if the ~~*home*~~ provider cannot produce proper accounting records of resident's funds or property, including receipts for purchases made using the resident's personal funds. Restitution of the funds to the resident is a condition for continued operation of the home; ~~*(4-11-06)*~~*( )*

~~*f*~~**g.** Not require the resident to purchase goods or services from or for the home other than those designated in ~~*the admission agreement*~~ Section 260 of these rules; ~~*(4-11-06)*~~*( )*

~~*g*~~**h.** Provide the resident, his legal guardian, his representative with financial power of attorney, and conservator access to the resident's funds ~~*to the resident, his legal guardian or conservator or another person of the resident's choice*~~; ~~*(4-11-06)*~~*( )*

~~*h*~~**i.** On the death of a private-pay resident, convey the resident's funds with a final accounting of those funds to the individual administering the resident's estate; within thirty (30) days as described in Section 210 of these rules; ~~*(4-11-06)*~~*( )*

~~*i*~~**j.** On the death of a ~~*client of the Department*~~ publicly-funded resident, convey the resident's funds, with a final accounting of those funds, to the Department within thirty (30) days as described in Section 210 of these rules. ~~*(4-11-06)*~~*( )*

276. -- 299. (RESERVED)

300. SHORT-TERM CARE AND SUPERVISION.
When the provider is temporarily ~~*unable*~~ unavailable to provide care or supervision to the resident, he may designate another adult to provide care and supervision, or only supervision ~~*only*~~ to the resident. The provider must assure that this short-term arrangement meets the needs of the resident and protects the resident from harm. ~~*(4-11-06)*~~*( )*

01. Alternate Caregiver. An alternate caregiver must be a certified family home provider. An alternate caregiver provides care and supervision in his home to a resident from another certified family home according to the resident's original plan of service and admission agreement. ~~*The provider is responsible to provide or arrange for resident-specific training for the alternate caregiver. Alternate care can be provided for up to thirty (30) consecutive days.*~~ The following applies to an alternate care placement: ~~*(4-11-06)*~~( )

a. The Department must approve an alternate care placement using the process described in Section 260 of these rules. The alternate caregiver must: ( )

i. Not exceed the number of residents for which his home is certified to provide care; ( )

ii. Comply with Section 140 of these rules when the resident receiving alternate care will be the third or fourth resident in the alternate caregiver's home; ( )

iii. Comply with Section 130 of these rules when the resident receiving alternate care requires nursing facility level of care and any other resident in the alternate caregiver's home requires nursing *facility* level of care. ( )

b. Upon approval from the Department, alternate care may be provided for up to thirty (30) consecutive days; and ( )

c. The provider must provide or arrange for resident-specific training to the alternate caregiver, including supplying copies of the resident's current assessment, plan of service, and admission agreement. ( )

02. Substitute Caregiver. A substitute caregiver must be ~~*approved*~~ an adult designated by the provider to provide care and supervision to the resident in the provider's certified family home. The following apply to the designation of a substitute caregiver: ( )

a. The provider is responsible to provide or arrange for resident-specific training for the substitute caregiver~~.~~ including reviewing copies of each resident's current assessment, plan of service, and admission agreement; ( )

b. Staffing levels in the home must be maintained at the same level as when the provider is available to provide care and supervision; ( )

c. Substitute care can be provided for up to thirty (30) consecutive days~~.~~; and ( )

d. ~~*In addition t*~~The substitute caregiver must have the following qualifications: ~~*(4-11-06)*~~( )

~~*a*~~i. Current certification in first aid and adult Cardio-Pulmonary Resuscitation (CPR) that meets the standards under Section 100 of these rules; ~~*(4-11-06)*~~( )

~~*b*~~ii. A criminal history check as provided in Section 009 of these rules; and (4-11-06)

~~*c*~~iii. ~~*Completed*~~ Completion of the "Assistance with Medications" course or other Department-approved training as provided in Section ~~*4*~~100 of these rules~~*, if they will assist the resident with medications*~~. ~~*(4-11-06)*~~( )

03. Incidental Supervision. An individual providing incidental supervision must be approved by the provider to supervise the resident. Incidental supervision must not include resident care. Incidental supervision may be provided for up to four (4) hours per week. (4-11-06)

301. -- 399. (RESERVED)

400. MEDICATION ~~*STANDARDS AND REQUIREMENTS*~~ POLICY.

~~***01. Medication Policy.***~~ The ~~*certified family home*~~ provider must ~~*develop*~~ possess and implement written medication policies and procedures that outline in detail how the home will assure appropriate assistance with

and handling of and safeguarding of medications. ~~This documentation~~ These policies and procedures must be maintained in the home, and include the following~~.~~: ~~(4-11-06)~~( )

~~**02. Handling of Resident's Medication**. (4-11-06)~~

~~**a.** The medication must be in the original pharmacy-dispensed container, or in an original over-the-counter container, or placed in a unit container by a licensed nurse and be appropriately labeled with the name of the medication, dosage, time to be taken, route of administration, and any special instructions. Each medication must be packaged separately unless in a Mediset, blister pack, or similar system. (4-11-06)~~

~~**b.** Evidence of the written or verbal order for the medication from the physician or other practitioner of the healing arts must be maintained in the resident's record. Medisets filled and labeled by a pharmacist or licensed nurse may serve as written evidence of the order. An original prescription bottle labeled by a pharmacist describing the order and instructions for use may also serve as written evidence of an order from the physician or other practitioner of the healing arts. (4-11-06)~~

~~**c.** The home is responsible to safeguard the resident's medications. (4-11-06)~~

~~**d.** Medications that are no longer used by the resident must not be retained by the certified family home for longer than thirty (30) calendar days. (4-11-06)~~

01. Following Orders. Assistance given by the provider must only be as directed by the resident's health care professionals. ( )

02. Evidence of Orders. Evidence of each resident's orders must be maintained in the home, regardless of whether the resident is able to self-administer, and may consist of the following: ( )

a. Written instructions from the health care professional for the medication including the dosage, expected effects, potential adverse reactions or side effects, and actions to take in an emergency; ( )

b. Medisets filled and appropriately labeled by a pharmacist or licensed nurse with the name of the medications, dosage, time to be taken, route of administration, and any special instructions; ( )

c. An original prescription bottle labeled by a pharmacist describing the order and instructions for use; and ( )

d. If the medication, supplement, or treatment is without a prescription, it will be listed among over-the-counter medications approved by the resident's health care professional as indicated by a signed statement. Over-the-counter medications will be given as directed on the packaging. ( )

03. Alteration of Orders. The provider must not alter dosage, discontinue or add medications, including over-the-counter medications and supplements, or discontinue, alter, or add treatments or special diets without first consulting the resident's prescribing health care professional and obtaining an order for the change as required under Subsection 400.02 of this rule. ( )

04. Allergies. The provider must list any known food or drug allergies for each resident and take precautions to guard against the resident ingesting such allergens. ( )

05. Training. Each adult assisting with resident medications must have successfully completed the "Assistance with Medications" course, or other Department-approved training as described in Section 100 of these rules. Additionally: ( )

a. Each resident's orders *must* be reviewed by each staff person assisting residents with medications prior to offering assistance; and ( )

b. Written instructions *must* be in place that outline who to notify if any of the following occur: ( )

i. Doses are not taken; ( )

ii. Overdoses occur; or ( )

iii. Side effects are observed. ( )

c. The provider must ensure any staff assisting with medications has reviewed each resident's known allergies and takes precautions against the resident ingesting such allergens. ( )

06. Self-administration. When the provider cares for a resident who self-administers his own medications, the provider must follow the standards described under Section 401 of these rules. ( )

07. Assistance with Medication. When the provider cares for a resident who needs assistance with medications, the provider must follow the standards described under Section 402 of these rules. ( )

401. SELF-ADMINISTRATION OF MEDICATION.

~~***03. Self-Administration of Medication.***~~ If the resident is responsible for administering his own medication without assistance, the provider must ensure the following: ( )

01. Approval. ~~*a*~~The provider must obtain written approval stating that the resident is capable of self-administration ~~*must be obtained*~~ from the resident's ~~*primary physician or other practitioner of the healing arts*~~ health care professional; otherwise, the provider must comply with the standards in Section 402 of these rules. ( )

02. Evaluation.The resident's record must ~~*also*~~ include documentation that ~~*a licensed nurse or other qualified professional*~~ the resident's health care professional has evaluated the resident's ability to safely self-administer medication, ~~*and has found that the resident*~~ The evaluation must include verification of the following: ~~*(4-11-06)*~~( )

a. The resident ~~*U*~~understands the purpose of ~~*the*~~each medication; ~~*(4-11-06)*~~( )

b. The resident is oriented to time and place and ~~*K*~~knows the appropriate dosage and times to take the medication; ~~*(4-11-06)*~~( )

c. The resident ~~*U*~~understands the expected effects, adverse reactions, or side effects, and knows what actions to take in case of an emergency; and ~~*(4-11-06)*~~( )

d. The resident ~~*I*~~is able to take the medication without assistance or reminders. ~~*(4-11-06)*~~( )

03. Change in Condition. Should the condition of the resident change such that it brings into question his ability to safely continue self-administration of medications, the provider must have a reevaluation and approval of the resident to self-administer as required in Subsections 401.01 and 401.02 of this rule. ( )

04. Safeguarding Medication. The provider must ensure that the medications of a resident who self-administers are safeguarded, including providing a lockable storage cabinet *or drawer* to the resident as described in Section 175 of these rules. Notwithstanding, the resident must be allowed to maintain his medications under his own control and possession. ( )

402. ASSISTANCE WITH MEDICATION.

~~***04. Assistance with Medications.***~~ The ~~*certified family home*~~ provider must ~~*provide*~~ offer assistance with medications to residents who need assistance; however, only a ~~*licensed nurse or other licensed*~~ health care professional may administer medications. Prior to assisting residents with medication, the provider must ensure the following conditions ~~*must be*~~ are in place: ~~*(4-11-06)*~~( )

~~*a*~~**01. Training**. Each person assisting with resident medications must be an adult who successfully completed and follows 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. ~~*Family*~~

~~members previously exempted from this requirement must complete this course before July 1, 2006.~~ ~~(4-11-06)~~( )

~~b~~02. **Condition of the Resident**. The resident's health condition is stable~~;~~. ~~(4-11-06)~~( )

~~c~~03. **Nursing Assessment**. The resident's health status does not require nursing assessment before receiving the medication nor nursing assessment of the therapeutic or side effects after the medication is taken~~;~~, unless the provider is a health care professional. ~~(4-11-06)~~( )

~~d~~04. **Containers and Labels**. The medication is in the original pharmacy-dispensed container with proper label and directions or in an original over-the-counter container. ( )

a. Each medication must be packaged separately unless in a Mediset, blister pack, or similar system. ( )

b. ~~or the m~~Medication ~~has been~~ may be placed in a unit container by a licensed nurse when the container is appropriately labeled with the name of the medications, dosage, time to be taken, route of administration, and any special instructions. ( )

c. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container~~;~~. ~~(4-11-06)~~( )

~~e. Written and oral instructions from the licensed physician or other practitioner of the healing arts, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency have been reviewed by the staff person;~~ ~~(4-11-06)~~

~~f. Written instructions are in place that outline required documentation of medication assistance, and whom to call if any doses are not taken, overdoses occur, or actual or potential side effects are observed; and~~ ~~(4-11-06)~~

~~g. Procedures for disposal/destruction of medications must be documented and consistent with procedures outlined in the "Assistance with Medications" course.~~ ~~(4-11-06)~~

05. Safeguarding Medications. The provider must take adequate precautions to safeguard the medications of each resident for whom he provides assistance. Safeguarding consists of the following: ( )

a. Storing each resident's medications in an area or container designated only for that particular resident including a label with the resident's name, except for medications that must be refrigerated *or over-the-counter medications*; ( )

b. Keeping the designated area or container for the resident's medications under lock and key when either of the following apply: ( )

i. The resident's medications include a controlled substance; or ( )

ii. Any resident in the home or other member of the household has drug-seeking behaviors. ( )

c. Ensuring each resident's designated *medication* area or container is clean and kept free of contamination, including disposal of loose pills in accordance with Subsection 402.08 of this rule; ( )

d. Dispensing only one (1) resident's set of medications from its designated area or container at one (1) time, so as to mitigate medication errors*; and* ( )

e. *On at least a monthly basis, document an inventory of narcotic medications.* ( )

0~~5~~6. **Administration of Medications**. Only a ~~licensed nurse or other licensed~~ health care professional~~s~~ working within the scope of ~~their~~ his license may administer medications. Administration of medications must comply with the Administrative Rules of the Board of Nursing, IDAPA 23.01.01, "Rules of the Idaho Board of

Nursing." Some ~~services~~ procedures are of such a technical nature that they must always be performed by, or under the direct supervision of, a ~~licensed nurse or other licensed~~ health care professional. These ~~services~~ procedures are outlined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Section 490. ~~(4-11-06)~~( )

07. Documentation of Assistance. Documentation of assistance with medications must be maintained by the provider. The documentation must: ( )

a. Be logged concurrent with the time of assistance; ( )

b. Contain at least the following information: ( )

i. The name of the resident receiving the medication; ( )

ii. The name of the medication given; ( )

iii. The dosage of the medication given; and ( )

iv. The time and date the medication was given. ( )

c. *Indicate the reason for assisting with any PRN medication*, including both over-the-counter and prescription medication. ( )

0~~6~~8. ~~Written Record of~~ Disposal of Medication. Medication that has been discontinued as ordered by the resident's health care professional, or has expired, must be disposed of by the provider within thirty (30) days of the order or expiration date. A written record of all disposal of drugs must be maintained in the home and ~~will~~ must include: ~~(4-11-06)~~( )

a. ~~A description of the drug, including the amount~~ The name of the medication; ~~(4-11-06)~~( )

b. The amount of the medication, including the number of pills at each dosage, if applicable; ( )

~~b~~c. The name of the resident for whom the medication was prescribed; ~~(4-11-06)~~( )

~~c~~d. The reason for disposal; (4-11-06)

e. The date on which the medication was disposed; ( )

~~d~~f. The method of disposal; and (4-11-06)

~~e~~g. ~~Signatures of responsible home personnel and a witness or the resident's family~~ A signed statement from the provider and a *credible* witness confirming the disposal of the medication. ~~(4-11-06)~~( )

40~~1~~3. -- 499. (RESERVED)

500. ENVIRONMENTAL SANITATION STANDARDS.
The ~~home~~ provider is responsible for disease prevention and maintenance of sanitary conditions in the home. ~~(4-11-06)~~( )

01. Water Supply. The water supply for the home must be adequate, safe, and sanitary. (4-11-06)

a. The home must use a public or municipal water supply or a Department-approved private water supply; (4-11-06)

b. If water is from a private supply, water samples must be submitted to an ~~private~~ accredited laboratory ~~or the District Public Health Laboratory for bacteriological examination~~ and show an absence of *bacterial* contamination at least annually, or more frequently if deemed necessary by the Department. Copies of the laboratory reports must be kept on file at the home; and ~~(4-11-06)~~( )

c. There must be ~~enough~~ adequate water pressure to meet ~~the~~ sanitary requirements at all times. ~~(4-11-06)~~( )

02. Sewage Disposal. The sewage disposal system must be in good working order. All sewage and liquid wastes must be discharged, collected, treated, and disposed of in a manner approved by the local municipality or the Department. ~~(4-11-06)~~( )

03. Nonmunicipal Sewage Disposal. ( )

a. For homes with nonmunicipal sewage disposal, at the time of the initial certification and at least every five (5) years thereafter, the ~~home~~ provider must ~~provide~~ obtain proof that the septic tank has been pumped or that pumping was not necessary, or that the system is otherwise in good working condition. ~~In addition, at the time of initial certification:~~ ~~(4-7-11)~~( )

~~a~~**b.** ~~The home must obtain a statement from the local health district indicating that the sewage disposal system meets local requirements. The statement must be kept on file at the home; or~~ The Department may require the provider to obtain a statement from the local or area health district indicating that the sewage disposal system meets local requirements. The statement must be kept on file at the home. ~~(4-11-06)~~( )

~~b. If the local health district does not issue these statements, the home must obtain a statement to that effect from the health district. The statement must be kept on file at the home.~~ ~~(4-11-06)~~

04. Garbage and Refuse Disposal. Garbage and refuse disposal must be provided by the home. (4-11-06)

a. Garbage containers outside the home used for storage of garbage and refuse must be constructed of durable, nonabsorbent materials and ~~must not leak or absorb liquids. Containers must~~ be provided with tight-fitting lids. ~~(4-11-06)~~( )

b. Garbage containers must be maintained in good repair and must not leak or absorb liquids. ( )

c. Sufficient containers must be available to hold all garbage and refuse ~~which~~ that accumulates between periods of removal from the premises. ( )

d. Storage areas must be kept ~~clean and sanitary~~ free of excess refuse and debris. ~~(4-11-06)~~( )

05. Insect and Rodent Control. The home must be maintained free from infestations of insects, rodents and other pests. ~~Chemicals (p~~Pesticides~~)~~ used in the control program must be selected, stored, and used safely. ~~(4-11-06)~~( )

a. The ~~chemical~~ pesticide must be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer; ~~(4-11-06)~~( )

b. The ~~home~~ provider must take ~~the~~ necessary precautions to protect the resident~~s~~ from obtaining toxic chemicals, as appropriate for his functional and cognitive ability. ~~(4-11-06)~~( )

06. Yard. The yard surrounding the home must be safe and maintained. (4-11-06)

07. ~~Linen~~ Laundry Facilities and Services. A washing machine and dryer must be ~~provided~~ readily available for the proper and sanitary washing of linen and other washable goods. Laundry services must be offered on at least a weekly basis, or more frequently when soiled linens or clothing create a noticeable odor. ~~(4-11-06)~~( )

08. Housekeeping and Maintenance. Sufficient housekeeping and maintenance must be provided to maintain the interior and exterior of the home in a clean, safe, and orderly manner. (4-11-06)

a. ~~A~~ Resident sleeping rooms must be thoroughly cleaned including the bed, bedding, ~~and~~ furnishings,

walls, and floors. Cleaning must occur on at least a weekly basis and immediately before ~~it is~~being occupied by a new resident~~;~~. ~~and~~ ~~(4-11-06)~~( )

b. Deodorizers must not be used to cover odors caused by poor housekeeping or unsanitary conditions. (4-11-06)

c. Cleaners and chemicals must be stored and used appropriately and safely. The provider must take necessary precautions to protect the resident from obtaining toxic chemicals, as appropriate for his functional and cognitive ability. ( )

501. -- 599. (RESERVED)

600. FIRE AND LIFE SAFETY STANDARDS.
~~Certified family~~ Each home~~s~~ must meet all applicable requirements of local and state codes concerning fire and life safety. ~~(4-11-06)~~( )

01. General Requirements. General requirements for the fire and life safety standards for a certified family home are: (4-11-06)

a. The home must be structurally sound and equipped and maintained to assure the safety of residents; and (4-11-06)

b. When natural or man-made hazards are present, suitable fences, guards, and railings must be provided to protect the residents according to their need for supervision as documented in the plan of service; and (4-11-06)

c. The ~~premises~~ exterior and interior of the ~~certified family~~ home must be kept free from the accumulation of weeds, trash, ~~and~~ debris, rubbish, and clutter. ~~(4-11-06)~~( )

02. Fire and Life Safety Requirements. (4-11-06)

a. Smoke ~~detectors~~ alarms must be installed in sleeping rooms, hallways, on each level of the home, and as recommended by the local fire district. ~~(4-11-06)~~( )

b. Carbon monoxide (CO) alarms must be installed as recommended when: ( )

i. The home is equipped with gas or other fuel-burning appliances or devices; or ( )

ii. An enclosed garage is attached to the home. ( )

c. Unvented combustion devices of any kind are prohibited from use inside the home. ( )

~~b~~**d.** Any locks installed on exit doors must be easily opened from the inside without the use of keys or any special knowledge~~;~~. ~~(4-11-06)~~( )

~~e~~**e.** An electric ~~P~~portable heating device~~s of any kind are prohibited~~ must only be used under the following conditions~~:~~: ~~(4-11-06)~~( )

i. The unit is maintained in good working order and without obvious damage or fraying of the cord; ( )

ii. The heating element does not exceed two hundred twelve degrees Fahrenheit (212°F); ( )

iii. The user complies with safety labels, which are to remain on the unit; ( )

iv. The unit is equipped with automatic shut-off protection when tipped over; and ( )

v. The unit is operated under direct supervision and at least thirty-six (36) inches away from

combustibles including furnishings, bedding, and blankets. ( )

~~d~~**f.** Homes that use fuel-fired stoves must provide adequate railings or other approved protection designed to prevent the resident~~s~~ from coming into contact with the stove surfaces, as appropriate for his functional and cognitive ability~~;~~. ~~(4-11-06)~~( )

~~e~~**g.** Each resident's sleeping room ~~will~~ must have at least one (1) door or window that can be easily opened from the inside and leads directly to the outside. If a window is used as a means of egress/ingress, the following conditions must be met: ( )

i. The window sill height must not be more than forty-four (44) inches above the finished floor~~.~~; ( )

ii. The ~~W~~window opening~~s~~ must be at least twenty ~~two~~ (2~~2~~0) inches in width and twenty-four (24) inches in height; and ~~(4-11-06)~~( )

iii. If the sleeping room is in a below-ground basement, the window must open into a window well through which the resident can easily exit. ( )

~~f~~**h.** Flammable or highly combustible materials must ~~not~~ be stored ~~in the home;~~ safely. The provider must take necessary precautions to protect the resident from obtaining flammable materials as appropriate for his functional and cognitive ability. ~~(4-11-06)~~( )

~~g~~**i.** Boilers, hot water heaters, and unfired pressure vessels must be equipped with automatic pressure relief valves~~;~~. ~~(4-11-06)~~( )

~~h~~**j.** A ~~P~~portable fire extinguisher~~s~~ must be mounted ~~throughout~~ on each level of the home ~~according to the configuration of the home~~. The ~~L~~location of fire extinguishers is subject to Department approval. All extinguishers must be at least five (5) pound dry chemical multipurpose 2A:10B:C type ~~and~~;. ~~(4-11-06)~~( )

~~i~~**k.** Electrical installations and equipment must comply with the applicable local and state electrical codes~~;~~. ~~(4-11-06)~~( )

~~j~~**l.** ~~Solid~~ ~~f~~Fuel-fired heating devices must be approved by the local ~~building/~~ heating/–venting/air conditioning (HVAC) board. ~~Openings in all solid fuel heating devices must have a door constructed of heat tempered glass or other approved material;~~ ~~(4-11-06)~~( )

~~k~~**m.** Exits must be free from obstruction~~;~~. ~~(4-11-06)~~( )

~~l~~**n.** ~~Doorways in the p~~Paths of travel to ~~an~~ exits and all exit doorways must be at least twenty-eight (28) inches wide~~;~~. ~~(4-11-06)~~( )

~~m~~**o.** The door into each bathroom and sleeping room must unlock from ~~the outside~~ both sides, if equipped with a lock, in case of an emergency. ~~(4-11-06)~~( )

03. Smoking. Smoking is a fire hazard. The ~~home~~ provider may choose to allow or not allow smoking. If the ~~home~~ provider chooses to allow smoking, ~~it~~ he must reduce the risk of fire by: ~~(4-11-06)~~( )

a. Prohibiting smoking in any area where flammable liquids, gases, or oxidizers are in use or stored; (4-11-06)

b. Prohibiting residents from smoking in bed; and (4-11-06)

c. Prohibiting unsupervised smoking by the resident~~s~~ unless unsupervised smoking is specifically allowed in ~~the~~ his plan of service. ~~(4-11-06)~~( )

04. Emergency Preparedness. Each ~~certified family home will~~ provider must develop and implement

a written emergency preparedness plan. ~~for emergencies including~~ The provider must review the emergency plan with the resident(s), or his representative, at admission and at least every six (6) months thereafter. The plan must address the following: ( )

a. ~~e~~Evacuation of the home~~.~~, including: ~~The emergency plan must be reviewed with residents at admission and at least every six (6) months thereafter. This review must be documented in each resident's individual file.~~ ~~(4-11-06)~~( )

i. A floor plan of the home depicting at least two (2) routes of escape from each room; ( )

ii. A designated meeting area indicated on the floor plan where all members of the household will congregate upon evacuation of the home; and ( )

iii. The person responsible to take a head-count at the designated meeting area and relay information to firefighters regarding the probable whereabouts in the home of missing individuals. ( )

b. Emergency situations in which people are confined to the home for a period of at least seventy-two (72) hours and considering adequate food, water, and medications during that time; ( )

c. Emergency situations in which people are ordered evacuated from the home, including pre-arranged plans to shelter within the local community and in a town outside the local community, and considering the necessary supplies that will be kept in a state of preparedness for quick evacuation; and ( )

d. Procedures for any situation in which the provider is incapacitated and unable to provide services. ( )

05. Fire Drills. ~~Homes~~ The provider must conduct and document fire drills at least quarterly. ( )

a. The provider must demonstrate the ability to evacuate all persons from the home to a point of safety outside the home within three (3) minutes. ( )

b. Residents who are ~~physically~~ medically unable to exit unassisted are exempt from physical participation in the drill if the provider has an effective evacuation plan for such residents and discusses the plan with the resident at the time of the drill. ~~(4-11-06)~~( )

c. Documentation, which may consist of video recordings or written logs, must include the following: ( )

i. The date and time of the drill; ( )

ii. The length of time for all persons able to participate in the drill to evacuate from the home; ( )

iii. The name or likeness of each caregiver who participated in the drill; and ( )

iv. The name or likeness of each resident and whether the resident participated in the drill. ( )

06. Report of Fire. A ~~separate~~ report on each fire incident occurring within the home must be submitted to the Department ~~within thirty (30) calendar days of the occurrence~~ as described in Section 210 of these rules. ~~The report must include date of incident, origin, extent of damage, how the fire was extinguished, and injuries, if any.~~ ~~(4-11-06)~~

07. Maintenance of Equipment. The ~~home~~ provider ~~will~~ must assure that all equipment is properly maintained. ~~(4-11-06)~~( )

a. ~~The~~ ~~s~~Smoke ~~detectors~~ and carbon monoxide alarms must be tested at least monthly and a written record of the test results maintained on file~~.~~. ~~(4-11-06)~~( )

b. If the smoke or carbon monoxide alarm has replaceable batteries, replacement of the batteries must occur at least every six (6) months or as indicated by a low battery, whichever occurs first. ( )

c. A smoke or carbon monoxide alarm must be replaced at the end of its useful life as indicated by the manufacturer. ( )

~~**b.**~~ **d.** Portable fire extinguishers must be serviced ~~*annually*~~ *every twelve (12) months* by an outside servicing agency or when the quarterly examination reveals issues with the extinguisher as described under Subsection 600.07.e. of this rule, *whichever occurs first*. Fire extinguishers purchased in the last twelve (12) months ~~*are exempt from annual*~~ *must be* service*d within twelve (12) months* ~~*if*~~ *from* the ~~*home has a*~~ dated receipt on file. *( )*

e. All portable fire extinguishers must be examined at least quarterly by the provider or a knowledgeable ~~*family*~~ member of the household, as indicated by his initials and date on a log, to determine that~~:~~: ~~*(4-11-06)*~~( )

i. The extinguisher is in its designated location; (4-11-06)

ii. Seals or tamper indicators are not broken and the safety pin is in place; ~~*(4-11-06)*~~( )

iii. The extinguisher has not been physically damaged; (4-11-06)

iv. The extinguisher does not have any obvious defects, such as leaks; ~~*and*~~ ~~*(4-11-06)*~~( )

v. ~~*Inspecting tags on each extinguisher show at least the initials of the person making the quarterly examinations and the date of the examinations.*~~ The nozzle is unobstructed; and ~~*(4-11-06)*~~( )

vi. Chemicals are prevented from settling and clumping by repeatedly tipping the extinguisher upside down and right-side up. ( )

~~**e.**~~ **f.** Fuel-fired heating systems must be inspected for safe operation, serviced if necessary, and approved at least annually by person(s) in the business of servicing these systems. The inspection records must be maintained on file in the home. ~~*(4-11-06)*~~( )

601. -- 699. (RESERVED)

700. HOME CONSTRUCTION AND PHYSICAL HOME STANDARDS.

01. General Requirements. Any residence used as a certified family home must be suitable for that use. Certified family homes must only be located in buildings intended for residential use. ~~*(4-11-06)*~~( )

a. Remodeling or additions to the home~~s~~ must be consistent with residential use of the property and must conform to local building standards including obtaining building permits as required by the local jurisdiction. ~~*Remodeling that is not consistent with the general practice of the neighborhood is not permitted. Examples may include converting garages to bedrooms or constructing large buildings which overwhelm the lot.*~~ ~~*(4-11-06)*~~( )

b. All homes are subject to Department approval. (4-11-06)

02. Walls and Floors. Walls and floors must withstand frequent cleaning. Walls in sleeping rooms must extend from floor to ceiling. (4-11-06)

03. Telephone. There must either be a ~~*landline*~~ telephone ~~*in the home that is accessible to all residents. The resident must have adequate privacy while using the telephone. The telephone must be immediately available in case of an emergency. Emergency numbers must be posted near the telephone.*~~ or an enhanced 911-compliant cell phone available to the resident. ~~*(4-11-06)*~~( )

a. If the home provides a cell phone for the resident's use, the provider must obtain documentation

from the service carrier that the cell phone is enhanced 911-compliant. ( )

b. The telephone or cell phone must: ( )

i. Be immediately available in case of an emergency; ( )

ii. Be functional and operational at all times, including having dependable service; ( )

iii. Be programmed with general emergency phone numbers and the emergency contacts for the resident, or alternatively, such numbers must be posted near the telephone; and ( )

iv. Be accessible to the resident throughout the day, including night hours, with unlimited usage and adequate privacy. ( )

04. Toilet Facilities and Bathrooms. ~~*Each certified family*~~ The home must contain: ~~*(4-11-06)*~~( )

a. At least one (1) flush toilet, one (1) tub or shower, and one (1) ~~*lavatory*~~ sink with a mirror; ~~*(4-11-06)*~~( )

b. Toilet ~~*facilities*~~ and shower or bath~~*rooms*~~ing facilities must be separated from all rooms by solid walls or partitions; ~~*(4-11-06)*~~( )

c. ~~*All*~~ Each room containing a toilet, shower, or ~~*facilities and*~~ bath~~*rooms*~~ must have either a window that is easily opened to the outside, or forced ventilation to the outside; ~~*(4-11-06)*~~( )

d. Tubs, showers, and ~~*lavatories*~~ sinks must be connected to hot and cold running water; and ~~*(4-11-06)*~~( )

e. Access to ~~*resident*~~ toilet facilities and bathrooms designated for the resident's use must not require ~~*a resident*~~ him to pass through another person's sleeping room ~~*to reach the toilet or bath*~~. ~~*(4-11-06)*~~( )

05. Accessibility for Residents with Physical and Sensory Impairments. ~~*Homes*~~ A provider choosing to provide services to a resident~~s~~ who ~~*have*~~ has difficulty with mobility or who ~~*have*~~ has sensory impairments must assure the physical environment meets the needs of the resident and maximizes independent mobility and use of appliances, bathroom facilities, and living areas. The home must provide necessary accommodations that meet the "American With Disabilities Act Accessibility Guidelines--Standards for Accessible Design (SFAD)," as incorporated by reference in Section 004 of these rules and as described below according to the individual resident's needs: ~~*(4-11-06)*~~( )

a. A ramp that complies with ~~*the Americans with Disabilities Act Accessibility Guidelines (ADAAG) 4.8*~~ Section 405 of the SFAD. Elevators or lifts that comply with Sections 409 and 410, respectively, may be utilized in place of a ramp; ~~*(4-11-06)*~~( )

b. ~~*Bathrooms and d*~~Doorways large enough to allow easy passage of a wheelchair and that comply with ~~*the ADAAG 4.13*~~ Subsection 404.2.3 of the SFAD; ~~*(4-11-06)*~~( )

c. Toilet and bathing facilities that comply with ~~*the ADAAG 4.16 and 4.23*~~ Sections 603 and 604 of the SFAD; ~~*(4-11-06)*~~( )

d. Sinks that comply with ~~*the ADAAG 4.24*~~ Section 606 of the SFAD; ~~*(4-11-06)*~~( )

e. Grab bars in resident toilet facilities and bathrooms that comply with ~~*the ADAAG 4.26*~~ Section 609 of the SFAD; ~~*(4-11-06)*~~( )

f. Bathtubs ~~*and*~~ or shower stalls that comply with ~~*ADAAG 4.20 and 4.21*~~ Sections 607 and 608 of the SFAD, respectively; ~~*(4-11-06)*~~( )

g. Non-retractable faucet handles that comply with ~~the ADAAG 4.19 and 4.27~~ Subsection 309.4 of the SFAD. Self-closing valves are not allowed; ~~(4-11-06)~~( )

h. Suitable handrails on both sides of all stairways leading into and out of the home that comply with ~~the ADAAG 4.9.4~~ Section 505 of the SFAD; and ~~(4-11-06)~~( )

i. Smoke and carbon monoxide alarms that comply with Section 702 of the SFAD. ( )

06. Storage Areas. Adequate storage must be provided in addition to the required storage in resident sleeping rooms. (4-11-06)

07. Lighting. Adequate lighting must be provided in all resident sleeping rooms and any other rooms accessed by the resident. (4-11-06)

08. Ventilation. The home must be well ventilated and the provider must take precautions to prevent offensive odors. (4-11-06)

09. Heating and Cooling. The temperature in the ~~certified family~~ home must be maintained ~~at~~ between ~~seventy~~ sixty-five degrees Fahrenheit (~~70~~65°F) ~~or more~~ and ~~seventy~~ eighty degrees Fahrenheit (80°F) ~~during waking hours~~ when residents or adult hourly care participants are at home. ~~and sixty five degrees Fahrenheit (65°F) or more during sleeping hours or as defined in the plan of service. Wood stoves must not be the primary source of heat and t~~The thermostat for the primary source of heat must be ~~remotely~~ located away from the wood stove, if applicable. ~~(4-11-06)~~( )

10. Plumbing. All plumbing in the home must be in good working order and comply with local and state codes. All plumbing fixtures must be easily cleanable and maintained in good repair. ~~(4-11-06)~~( )

11. Resident Sleeping Rooms. ~~(4-11-06)~~( )

a. The ~~resident's~~ sleeping room must not be in an attic, stairway, hall, or any room commonly used for other than bedroom purposes. ( )

b. The ~~resident's~~ sleeping room~~s~~ may be in a below-ground basement or a room *located on the second story or higher* only if the following conditions are met: ~~(4-11-06)~~( )

i. ~~The window must not open into a window well that cannot be exited. All other fire and life safety requirements for windows must be met~~ The resident is able to independently recognize an emergency and self-evacuate from his sleeping room without physical assistance or verbal cueing as assessed and indicated in his plan of service; or ~~(4-11-06)~~( )

ii. The provider's sleeping room or the sleeping room of another responsible and able-bodied individual living in the home is located on the same level with the resident's sleeping room; and ( )

iii. The ~~basement must have~~ level of the home on which the resident's sleeping room is located has floors, ceilings, and walls ~~which~~ that are finished to the same degree as the rest of the home. ~~The sleeping room must meet all other requirements of these rules; and~~ ~~(4-11-06)~~( )

~~iii. The resident must be assessed through the plan of service to be capable of evacuating from the basement without assistance in an emergency.~~ ~~(4-11-06)~~

~~b~~**c.** Walls must run from floor to ceiling and doors must be solid~~;~~. ~~(4-11-06)~~( )

~~e~~**d.** The resident must not occupy the same bedroom as the provider. The resident must not occupy the same bedroom as ~~the provider's family~~ a relative of the provider unless the ~~resident~~ relative is ~~also~~ a ~~family member~~ sibling of the resident~~;~~. ~~(4-11-06)~~( )

~~d~~**e.** The ~~C~~ceiling height~~s~~ in the sleeping room~~s~~ must be at least seven feet, six inches (7'6")~~;~~.

~~(4-11-06)~~( )

~~e~~**f.** The ~~S~~sleeping room~~s~~ must have a closet~~s~~ *that must be* equipped with a door~~s~~ if the resident so chooses. ( )

i. Closet space shared by two (2) residents~~,~~ must have a substantial divider separating each resident's space. ( )

ii. Free-standing closet~~s~~ space must be deducted from the square footage in the sleeping room~~; and~~. ~~(4-11-06)~~( )

~~f~~**g.** The ~~S~~sleeping room~~s~~ must have at least one-hundred (100) square feet of floor space in a one (1) person sleeping room and at least one-hundred and sixty (160) square feet of floor space in a two (2) person sleeping room. ~~(4-11-06)~~( )

701. MANUFACTURED HOMES AND MODULAR BUILDINGS.

01. Use of Manufactured Homes and Modular Buildings. Idaho Division of Building Safety (~~B~~DBS) approved modular buildings or U.S. Department of Housing and Urban Development (HUD) approved buildings may be approved for use as a certified family home when the home meets the following requirements~~.~~: ~~(4-7-06)~~( )

a. The manufactured or modular home meets the requirements of HUD or ~~B~~DBS requirements in accordance with state and federal regulations as of the date of manufacture. ~~(4-7-06)~~( )

b. The manufactured or modular home meets the adopted standards and requirements of the local jurisdiction in which the home is located. ~~(4-7-06)~~( )

c. Recreational vehicles, commercial coaches, unregulated or unapproved modifications or additions to approved manufactured housing or modular buildings~~; and~~ will not be approved by the Department. ( )

d. ~~m~~Manufactured housing constructed prior to June 15, 1976, ~~are~~ is prohibited for use as a certified family home without ~~DHW~~ assessment and approval by the Department. ~~(4-7-06)~~( )

02. Previously Certified. A manufactured home approved for use as a certified family home before July 1, 2001, may continue to be certified when evaluated on a case-by-case basis. (4-7-11)

702. -- 709. (RESERVED)

710. SITE REQUIREMENTS FOR CERTIFIED FAMILY HOMES.
In addition to the requirements of Section 700 of these rules, ~~certified family~~ the home~~s~~ must comply with the following site requirements~~.~~: ~~(4-11-06)~~( )

01. Fire District. The home must be in a lawfully constituted fire district. (4-11-06)

02. Accessible Road. The home must be served by an all-weather road kept open to motor vehicles at all times of the year. (4-11-06)

03. Emergency Medical Services. The home must be accessible to emergency medical services ~~within thirty (30) minutes driving time; and~~. ~~(4-11-06)~~( )

04. Accessible to Services. The home must be accessible ~~within thirty (30) minutes driving time~~ to necessary social, medical, and rehabilitation services. ~~(4-11-06)~~( )

05. House Number. The house number must be prominently displayed and plainly visible from the street. ( )

711. -- 899. (RESERVED)

900. EMERGENCY POWERS OF THE DIRECTOR.
In the event of an emergency endangering the life or safety of a resident, the Director may summarily suspend or revoke any certified family home certificate. As soon thereafter as practical, the Director will provide an opportunity for a hearing in accordance with the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (4-11-06)

901. ENFORCEMENT PROCESS.
If the Department finds that ~~a home~~ the provider does not meet, or did not meet, a rule governing certified family homes, it may impose a remedy, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal. ~~(4-11-06)~~( )

01. Recommendation of Remedy. In determining which remedy to recommend, the Department will consider the ~~home's~~ provider's compliance history, ~~change of ownership~~ complaints, and the number ~~of deficiencies~~, scope, and severity of the deficiencies. Subject to these considerations, the Department may impose any of the following remedies: ~~(4-11-06)~~( )

a. Ban on all admissions~~, see~~ in accordance with Section 910 of these rules; ~~(4-11-06)~~( )

b. Ban on admissions of residents with certain diagnosis~~, see~~ in accordance with Section 911 of these rules; ~~(4-11-06)~~( )

c. Summarily suspend the certificate and transfer residents~~, see~~ in accordance with Section 912 of these rules; ~~(4-11-06)~~( )

d. Issue a provisional certificate~~, see~~ in accordance with S~~ubs~~ection ~~110.02~~909 of these rules; ~~or~~ and ~~(4-11-06)~~( )

e. Revoke the home's certificate~~, see~~ in accordance with Section 913 of these rules. ~~(4-11-06)~~( )

02. Notice of Enforcement Remedy. The Department will give the ~~home~~ provider written notice of an enforcement remedy by certified mail or by personal service upon its decision. The notice will include the decision, the reason for the Department's decision, and how to appeal the decision subject to the hearing provisions in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ~~(4-11-06)~~( )

902. FAILURE TO COMPLY.
The Department may ~~institute an action to~~ revoke the ~~home's~~ provider's certificate when ~~the Department~~ it determines ~~the home is out of compliance.~~ any of the following conditions exist: ~~(4-11-06)~~( )

01. Out of Compliance. ~~A home~~ The provider has not complied with ~~a program requirement~~ any part of these rules within thirty (30) days of the date the home is found out of compliance with that requirement. ~~(4-11-06)~~( )

02. Lack of Progress. ~~A home~~ The provider has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted the ~~home's~~ provider's plan of correction. ~~(4-11-06)~~( )

903. REPEATED NONCOMPLIANCE.
When the Department ~~makes a~~ determin~~ation~~es ~~of~~ that a provider has repeated noncompliance with ~~respect to a home~~ any of these rules, ~~the Department~~ it may impose any of the enforcement remedies listed in Sections 9~~1~~09 through 913 of these rules. ~~The Department will monitor the home on an as-needed basis, until the home has demonstrated that it is in compliance with all program requirements governing homes and that it will remain in compliance.~~ ~~(4-11-06)~~( )

904. -- 90~~9~~8. (RESERVED)

909. ENFORCEMENT REMEDY OF PROVISIONAL CERTIFICATION.
When the Department finds that the provider is unable to meet a standard required under these rules because of conditions that are not anticipated to continue beyond six (6) months and do not jeopardize the health or safety of the residents, the Department may grant a provisional certificate to the provider as described under Section 110 of these rules. ( )

01. Conditions of Provisional Certification. The Department, at its discretion, may impose conditions upon the provider, which will be included with the notice of provisional certification, if so imposed. Conditions are imposed to ensure the provider achieves compliance with the requirements of these rules and to aid the Department in monitoring the provider's performance during the provisional certification period. ( )

02. Failure to Meet Conditions of Provisional Certification. Failure by the provider to meet the conditions of a provisional certificate is cause for the Department to revoke the provider's certificate. ( )

03. Certification or Revocation. The Department, upon review of the provider's performance during the course of the provisional certification period, may either issue a certificate to the provider when the Department finds that the provider has achieved substantial compliance with these rules, or revoke the provider's certificate if the provider has failed to comply. ( )

910. ENFORCEMENT REMEDY OF BAN ON ALL ADMISSIONS.
All admissions to the home are banned pending satisfactory correction of all deficiencies. Bans will remain in effect until the Department determines that the ~~*home*~~ provider has achieved full compliance with all ~~*program*~~ requirements of these rules, or until a substitute remedy is imposed. ~~*(4-11-06)*~~( )

911. ENFORCEMENT REMEDY OF BAN ON ADMISSIONS OF RESIDENT WITH SPECIFIC DIAGNOSIS.
The Department may ban ~~*A*~~admission ~~*of*~~ into the home any resident with a specific diagnosis ~~*is banned*~~ when the Department has determined the provider lacks the skill to provide adequate care to such a resident. A ban may be imposed for all prospective residents, both ~~*state*~~ publicly and privately funded, and will prevent the home from admitting ~~*the kinds of*~~ residents with a specific diagnosis for whom ~~*it*~~ the provider has shown an inability to provide adequate care as described in Section 170 of these rules. ~~*(4-11-06)*~~( )

912. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF RESIDENT.
The Department may summarily suspend ~~*a home's*~~ the provider's certificate and transfer the resident when convinced by a preponderance of the evidence that the resident's health and safety are in immediate jeopardy. ~~*(4-11-06)*~~( )

913. ENFORCEMENT REMEDY OF REVOCATION OF CERTIFICATE.

01. Revocation of the ~~*Home's*~~ Certificate. The Department may institute a revocation action when persuaded by a preponderance of the evidence that the ~~*home*~~ provider is not in substantial compliance with ~~*this chapter*~~ these rules. ~~*(4-11-06)*~~( )

02. Causes for Revocation of the Certificate. The Department may revoke any certificate ~~*to include*~~ for any of the following causes: ~~*(4-11-06)*~~( )

a. The ~~*certificate holder*~~ provider has willfully misrepresented or omitted any of the following: ( )

i. ~~*i*~~Information ~~*on the application or other documents pertinent to obtaining a certificate*~~ pertaining to his certification; or ~~*(4-11-06)*~~( )

ii. Information obstructing an investigation. ( )

b. The home is not in substantial compliance with these rules; (4-11-06)

c. When persuaded by a preponderance of the evidence that such conditions exist which endanger the health or safety of any resident; (4-11-06)

d. Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person or persons in charge of the home. Such acts may include, but are not limited to, neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; (4-11-06)

e. The provider has demonstrated or exhibited a lack of sound judgment essential to the operation and management of a certified family home; ~~(4-11-06)~~( )

f. The provider has violated any of the conditions of a provisional certificate; (4-11-06)

g. The ~~home~~ provider has one (1) or more core issues~~. A core issue is a deficiency that endangers the health, safety, or welfare of any resident~~; ~~(4-11-06)~~( )

h. An accumulation of minor violations that, when taken as a whole, ~~would~~ constitute ~~a major deficiency~~ inadequate care; ~~(4-11-06)~~( )

i. Repeat violations of any requirement of these rules or of the Idaho Code; (4-11-06)

j. The ~~home~~ provider lacks the ability to properly care for the ~~type of~~ resident~~s residing at the home~~, as required by these rules, or as directed by the Department; ~~(4-11-06)~~( )

k. The ~~home~~ provider is not in substantial compliance with the provisions for services, resident rights, or admissions; ~~(4-11-06)~~( )

l. ~~Certificate holder~~ The provider refuses to allow the certifying agent or other representative of the Department or ~~P~~protection and ~~A~~advocacy agencies full access to the home ~~environment~~, ~~home~~ records, or the residents; ~~(3-21-12)~~( )

~~**m.** Any condition exists in the home which endangers the health or safety of any resident; or (3-21-12)~~

~~n~~m. The provider fails to pay the certification fee as specified in S~~ubs~~ection 109~~.02~~ of these rules. The certification fee is considered delinquent if not paid within thirty (30) days of due date on the invoice. ~~(3-21-12)~~( )

914. (RESERVED)

915. TRANSFER OF RESIDENT.
The Department may require transfer of a resident from a certified family home to an alternative placement on the following grounds~~.~~: ~~(4-11-06)~~( )

01. Violation of Rules. As a result of a violation of a provision of these rules or standards, the ~~home~~ provider is unable or unwilling to provide an adequate level of meals, lodging, personal assistance, or supervision of a resident. ~~(4-11-06)~~( )

02. Violation of Resident's Rights. A violation of a resident's rights provided in Section 39-3516, Idaho Code, or Section 200 of these rules. (4-11-06)

03. Immediate Jeopardy. A violation of a provision of ~~this chapter~~ these rules, or applicable rules or standards, results in conditions that present an immediate jeopardy. (4-11-06)

916. -- 949. (RESERVED)

950. RIGHT TO SELL.
Nothing contained in these rules limits the right of any home owner to sell, lease, mortgage, or close any certified family home in accordance with all applicable laws. ~~(4-11-06)~~( )

951. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.17 – RULES GOVERNING RESIDENTIAL HABILITATION AGENCIES

DOCKET NO. 16-0417-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 39-4605, Idaho Code.

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

This chapter of rules is being repealed under this docket and completely rewritten under companion Docket No. 16-0417-1702.

The companion docket 16-0417-1702, details the Residential Habilitation rules being completely rewritten to meet current best practices for residential habilitation agencies operating in Idaho and to update and revise the certification requirements for these agencies. The rules have not been updated for several years and amending these requirements for certification and removing obsolete language will make them more user-friendly.

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 2, 2017, Idaho Administrative Bulletin, **Vol. 17-8, pages 42 and 43**.

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 related to this rulemaking. These changes are intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Eric Brown at (208) 334-0649.

DATED this 16th day of November, 2017.

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 PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 39-4605, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held a the below DHW Office as follows:

PUBLIC HEARING Friday, August 11, 2017 1:00 p.m. (Local)	PUBLIC HEARING Monday, August 14, 2017 1:30 p.m. (Local)	PUBLIC HEARING Thursday, August 17, 2017 1:30 p.m. (Local)
Northern Idaho 1120 Ironwood Drive, Ste. 102 Large Conference Rm. Coeur d'Alene, ID 83814	Central Idaho 3232 W. Elder Street Conf. Rm D - West/East Boise, ID 83705	Southeastern Idaho 1070 Hiline Road Room 230 Pocatello, ID 83201

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:

This chapter of rules is being repealed under this docket and completely rewritten under companion Docket No. 16-0417-1702.

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

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

There is no anticipated fiscal impact to the state general fund or any other funds related to this rulemaking. These changes are 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 December 7, 2016, Idaho Administrative Bulletin, **Vol. 16-12, pages 74 and 75**; in the January 4, 2017, Idaho Administrative Bulletin, **Vol. 17-1, page 125**; and in the February 1, 2017, Idaho Administrative Bulletin, **Vol. 17-2, page 29**. Six negotiated meetings were conducted around the state in Boise, Twin Falls, Pocatello, Idaho Falls, Lewiston, and Coeur d'Alene from December 2016 through February 2017. The Department also held earlier negotiated meetings in 2016.

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 Eric Brown at (208) 334-0649.

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 23, 2017.

DATED this 10th day of July, 2017.

LSO Rules Analysis Memo

IDAPA 16.04.17 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.17 – RULES GOVERNING RESIDENTIAL HABILITATION AGENCIES

DOCKET NO. 16-0417-1702 (CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 39-4605, Idaho Code.

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

This chapter of rules was completely rewritten to meet current best practices for residential habilitation agencies operating in Idaho and the certification requirements for these agencies were revised and updated. Amending these requirements for certification and removing obsolete language will make these rules more user-friendly.

The current Residential Habilitation chapter is being repealed under companion Docket No. 16-0417-1701 to make way for this rewrite.

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 2, 2017, Idaho Administrative Bulletin, **Vol. 17-8, pages 44 through 69**.

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 related to this rulemaking. These changes are intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Eric Brown at (208) 334-0649.

DATED this 16th day of November, 2017.

Tamara Prisock
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Fax: (208) 334-6558
E-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 39-4605, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held at the below DHW Offices as follows:

PUBLIC HEARING Friday, August 11, 2017 1:00 p.m. (Local)	PUBLIC HEARING Monday, August 14, 2017 1:30 p.m. (Local)	PUBLIC HEARING Thursday, August 17, 2017 1:30 p.m. (Local)
Northern Idaho **1120 Ironwood Drive, Ste. 102** **Large Conference Rm.** **Coeur d'Alene, ID 83814**	**Central Idaho** **3232 W. Elder Street** **Conf. Rm D - West/East** **Boise, ID 83705**	**Southeastern Idaho** **1070 Hiline Road** **Room 230** **Pocatello, ID 83201**

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:

This chapter of rules is being completely rewritten to meet current best practices for residential habilitation agencies operating in Idaho and to update and revise the certification requirements for these agencies. The rules have not been updated for several years and amending these requirements for certification and removing obsolete language will make them more user-friendly.

The new chapter amends and updates:

1. Legal and informational sections;
2. Terms and Definitions;
3. Certification requirements; and
4. Enforcement remedies.

The current chapter is being repealed under companion Docket No. 16-0417-1701 to make way for this rewrite.

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

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

There is no anticipated fiscal impact to the state general fund or any other funds related to this rulemaking. These changes are 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 December 7, 2016, Idaho Administrative Bulletin, **Vol. 16-12, pages 74 and 75**; in the January 4, 2017, Idaho Administrative Bulletin, **Vol. 17-1, page 125**; and in the February 1, 2017, Idaho Administrative Bulletin, **Vol. 17-2, page 29**. Six

negotiated meetings were conducted around the state in Boise, Twin Falls, Pocatello, Idaho Falls, Lewiston, and Coeur d'Alene from December 2016 through February 2017. The Department also held earlier negotiated meetings in 2016.

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 Eric Brown at (208) 334-0649.

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 23, 2017.

DATED this 10th day of July, 2017.

LSO Rules Analysis Memo

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

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0417-1702

IDAPA 16
TITLE 04
CHAPTER 17

16.04.17 – RULES GOVERNING RESIDENTIAL HABILITATION AGENCIES

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under the Developmental Disabilities Services and Facilities Act, Sections 39-4601 et seq., Idaho Code, and under Section 56-1003, Idaho Code, to adopt and enforce rules, standards, and certification criteria for Residential Habilitation Agencies and provide for the delivery of appropriate services of habilitation and rehabilitation to the eligible population. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies." ( )

02. Scope. These rules govern: ( )

a. The certification of residential habilitation agencies; and ( )

b. Establish standards and minimum requirements for agencies that provide *residential habilitation*

services. The provisions are intended to regulate agencies so that services to participants will optimize participant opportunities for independence and self-determination while assuring adequate supports, services, participant satisfaction, and health and safety. Residential habilitation agencies will provide individualized services and supports encouraging participant choice, providing the greatest degree of independence possible, enhancing the quality of life, and maintaining community integration and participation. Services provided by such agencies are intended to be person-centered and participant-driven, and based on a person-centered plan to meet each participant's needs for self-sufficiency, medical care, and personal development with goals that safely encourage each participant to become a productive member of the community in which he lives. Access to these services must be authorized in accordance to the procedures of the paying entity. ( )

002. WRITTEN INTERPRETATIONS.
There are no written interpretations for these rules. ( )

003. ADMINISTRATIVE APPEALS.
Contested case hearings are governed according to the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

004. INCORPORATION BY REFERENCE.
There are no documents that have been incorporated by reference into this chapter of rules. ( )

005. OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS – TELEPHONE – WEBSITE.

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

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

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

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

05. Internet Website. The Department's internet website is http://www.healthandwelfare.idaho.gov/. ( )

06. Division of Licensing and Certification. The Department's Division of Licensing and Certification Unit is located at 3232 Elder Street, Boise, ID 83705; Phone: (208) 334-6626. ( )

07. Division Webpage. The Division of Licensing and Certification's website is http://www.healthandwelfare.idaho.gov/Medical/LicensingCertification. ( )

006. PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.
Any disclosure of information obtained by the Department is subject to the restrictions contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

007. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Verification of Compliance. The agency must verify that all employees and subcontractors delivering residential habilitation agency services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Requirement to Report Additional Criminal Convictions, Pending Investigations, or Pending Charges. Once an employee or subcontractor delivering residential habilitation agency services has received a

criminal history clearance, any additional criminal convictions, pending investigations, or pending charges must be reported to the Department or its designee *by the close of the next business day* when the agency learns of the convictions, investigations, or charges. *( )*

010. DEFINITIONS -- A THROUGH N.
For the purposes of these rules the following terms are used as defined below: ( )

01. Abuse. The non-accidental act of sexual, physical, verbal, or mental mistreatment, or injury of a resident through the action or inaction of another individual. ( )

02. Administrator. The individual who has primary responsibility for the direction and control of an agency. ( )

03. Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a person with developmental disabilities. A participant may act as his own advocate. ( )

04. Agency. Any business entity that directly provides residential habilitation services. *( )*

05. Board. The Idaho Board of Health and Welfare. ( )

06. Certificate. A permit to operate a residential habilitation agency. ( )

07. Complaint. A formal expression of dissatisfaction, discontent, or unhappiness by or on behalf of a participant concerning the services provided by the agency. This expression can be oral, in writing, or by alternative means of communication. ( )

08. Complaint Investigation. An investigation of an agency to determine the validity of allegations of non-compliance with applicable state rules. ( )

09. Deficiency. A determination of non-compliance with a specific rule, or part of a rule. ( )

10. Department. The Idaho Department of Health and Welfare, or a person authorized to act on behalf of the Department. ( )

11. Direct Service Staff. Any individual employed by the agency that provides direct services and supports to the participant. ( )

12. Director. Director of the Idaho Department of Health and Welfare, or his designee. ( )

13. Exploitation. An action that may include, but is not limited to, the unjust or improper use of a vulnerable participant's financial power of attorney, funds, property, or resources by another person for profit or advantage. ( )

14. Functional Assessment. An evaluation of the participant's strengths, needs, and interests that guides the development of program plans or plan of care. ( )

15. Governing Authority. The designated person or persons (i.e., board) who assume full responsibility for the conduct and operations of the residential habilitation services agency. ( )

16. Guardian. A legally-appointed person who has decision-making responsibility for the care or property of another, under *Section 15-5-301, et seq., Idaho Code, or* Section 66-404, Idaho Code. *( )*

17. Habilitation services. Service 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: self-direction, money management, daily living skills, socialization, mobility, and behavior-shaping and management. ( )

18. Immediate Jeopardy. A situation in which the provider's non-compliance with one (1) or more requirements in this chapter of rules has caused, or is likely to cause, serious injury, harm, impairment, or death to a participant. ( )

19. Inadequate Care. The failure to provide the services required to meet the terms of the plan of service. ( )

011. DEFINITIONS -- M THROUGH Z.
For the purposes of these rules the following terms are used as defined below: ( )

01. Measurable Objective. A statement that specifically describes the skill to be acquired or the service or support to be provided, includes quantifiable criteria for determining progress towards and attainment of the service, support or skill, and identifies a projected date of attainment. ( )

02. Medication. Any substance or drug used to treat a disease, condition, or symptoms that may be taken orally, injected, or used externally, and is available through prescription or over-the-counter. ( )

03. Neglect. The failure to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health of a vulnerable adult. ( )

04. Owner. Any person or entity, having legal ownership of the agency as an operating business, regardless of who owns the real property. ( )

05. Participant. An adult who is receiving residential habilitation services. *( )*

06. Physical Restraint. Any manual method that restricts the free movement of, normal functioning of, or normal access to, a portion or portions of an individual's body. Excluded are physical guidance and prompting techniques of brief duration *utilized to assist a participant with completing a desired action for himself*. *( )*

07. Physician. Any person licensed as required by Title 54, Chapter 18, Idaho Code. ( )

08. Plan of Service. An initial or annual plan that identifies all services and supports based on a planning process. Plans are authorized annually. ( )

09. Program Plan. The participant's plan that details how the participant's individualized goals will be addressed. ( )

10. Progress Note. A written notation, recording participant response to program objective, date, time, duration, and type of service signed and dated by the staff that provided services. ( )

11. PRN (Pro Re Nata) Medication. A medication that is given "as needed" or "as the circumstances warrant" to treat a symptom of a medical or psychiatric condition that has a periodic, episodic, or breakthrough presentation. The assistance with PRN medications must be provid*ed* as outlined in IDAPA 23.01.01*.490*, "Rules for the Idaho Board of Nursing-Unlicensed Assistive personnel (UAP)." *( )*

12. Provisional Certificate. A certificate issued by the Department to a residential habilitation agency with deficiencies that do not adversely affect the health or safety of participants. A provisional certificate is issued contingent upon the correction of deficiencies in accordance with an agreed-upon plan. A provisional certificate is issued for a specific period of time, up to, but not to exceed, six (6) months. ( )

13. Quarterly. For the purpose of these rules, quarterly is defined as every three (3) months. ( )

14. Residential Habilitation. Services consisting of an integrated array of individually tailored services and supports furnished to an eligible participant that are designed to assist him to reside successfully in his own home, with his family, or alternate family home. Residential habilitation includes habilitation services, personal care services, and skill training. Individuals who provide residential habilitation services must be employed by a residential habilitation agency. *( )*

15. **Residential Habilitation Professional**. An individual who has at least one (1) year of experience working directly with individuals with intellectual disabilities or developmental disabilities, and meets the requirements in 42 CFR 483.430 (a). ( )

16. **Self-Neglect**. The failure of a vulnerable adult to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health for himself. ( )

17. **Services**. Paid services authorized on the plan of service that enable the individual to reside safely and effectively in his own home. ( )

18. **Skill Training**. To train direct service staff to teach the participant how 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. ( )

19. **Substantial Compliance**. An agency is in substantial compliance with these rules when none of the following issues have been cited against the agency: ( )

a. Abuse; ( )

b. Neglect; ( )

c. Exploitation; ( )

d. Inadequate care; ( )

e. A situation in which the agency has operated more than thirty (30) days without an administrator or a residential habilitation professional; or ( )

f. Surveyors denied access to records, participants, or agency premises. ( )

20. **Supervision**. Initial and ongoing oversight of service and support elements by the residential habilitation professional or designee. The designee will report directly to the residential habilitation professional. ( )

21. **Survey**. A review conducted by a surveyor to determine an agency's compliance with statutes and rules. ( )

22. **Surveyor**. A person authorized by the Department to conduct surveys or complaint investigations to determine compliance with statutes and rules. ( )

012. -- 099. (RESERVED)

100. TYPES OF CERTIFICATES ISSUED.
The Department issues certificates that are in effect for a period of no longer than three (3) years. The types of certificates issued are as follow: ( )

01. **Initial Certificate**. When the Department determines that all application requirements have been met, an initial certificate is issued for a period of up to six (6) months from the initiation of services. The Department will survey the agency prior to the certificate expiration date to ensure the agency's ongoing capability to provide services and is in substantial compliance with these rules. When the agency is determined to be in substantial compliance, a one (1) year certificate will be granted. ( )

02. **One-Year Certificate**. A one (1) year certificate is issued by the Department when it determines the agency is in substantial compliance with these rules, following an initial or provisional certificate, or when there may be areas of deficient practice which would impact the agency's ability to provide adequate care. An agency is prohibited from receiving consecutive one (1) year certificates. ( )

03. Three-Year Certificate. A three (3) year certificate is issued by the Department when it determines the agency requesting certification is in substantial compliance with these rules. ( )

04. Provisional Certificate. When an agency is found to be out of substantial compliance with these rules, but does not have deficiencies that jeopardize the health or safety of participants, a provisional certificate may be issued by the Department for up to a six (6) month period. A provisional certificate is issued contingent upon the correction of deficiencies in accordance to a plan developed by the agency and approved by the Department. Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules. If the Department determines the agency is in compliance, a one (1) year certificate will be issued. If the agency is determined to be out of compliance, the certificate will be revoked. ( )

101. CERTIFICATION – GENERAL REQUIREMENTS FOR AGENCIES.

01. Certificate Required. ( )

a. No agency may provide services within this state until the Department has approved the application for certification and issued the agency a certificate. No agency may provide services within this state without a current certificate. ( )

b. The Department is not required to consider the application of any operator, administrator, or owner of an agency whose license or certification has been revoked until five (5) years have lapsed from the date of revocation. ( )

02. Application. An application for a certificate must be made to the Department on forms provided by the Department at: www.ddacertification.dhw.idaho.gov. The application must contain the following to be considered complete: ( )

a. Application form that contains the name, address, and telephone number of the agency, type of services to be provided, the geographic service area of the agencies, and the anticipated date for the initiation of services; ( )

b. An accurate and complete statement of all business names of the agency as filed with the Secretary of State, whether an assumed business name, partnership, corporation, limited liability company, or other entity, that identifies each owner of the agency, and the management structure of the agency; ( )

c. A statement that the agency will comply with these rules and all other applicable local, state, and federal requirements, including an assurance that the agency complies with pertinent state and federal requirements governing equal opportunity and nondiscrimination; ( )

d. A copy of the proposed organizational chart or plan for staffing of the agency; ( )

e. Staff qualifications including resumes, job descriptions, verification of satisfactory completion of criminal history checks in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," and copies of state licenses and certificates for staff, when applicable; ( )

f. Written policies and procedures for the development and implementation of staff training to meet the requirements of Section 204 of these rules. ( )

g. Staff and participant illness policy, communicable disease policy, and other health-related policies and procedures required in Section 300 of these rules; ( )

h. Written policies and procedures that address special medical or health care needs of participants required in Section 300 of these rules; ( )

i. Written transportation safety policies and procedures required in Section 300 of these rules; ( )

j. Written participant grievance policies and procedures to meet requirements in Section 300 of these rules; ( )

k. Written medication policies and procedures to address medication standards and requirements to meet requirements in Section 302 of these rules; ( )

l. Written policies and procedures that address the development of participants' social skills and the management of participants' maladaptive behavior to meet requirements in Section 303 of these rules; ( )

m. Written termination policies and procedures in accordance with Section 400 of these rules; ( )

n. Written policies and procedures for reporting incidents to the adult protection authority and to the Department to meet requirements in Section 404 of these rules; ( )

o. Written description of the program records system including a completed sample of a program plan, and a monitoring record; ( )

p. Written description of the fiscal record system including a sample of program billing; ( )

q. Written description of the agency's quality assurance program developed to meet requirements in Section 405 of these rules; ( )

r. Any other policies, procedures, or requirements as outlined in these rules; and ( )

s. All referenced forms. ( )

03. Applications Must Be Complete. Incomplete applications will not be considered and will be returned to the applicant. An applicant may submit an application up to three (3) times within a three hundred sixty-five (365) day period starting on the date of the first submission. If the application is incomplete upon a third submission, the application will be denied. The applicant may not resubmit an application for six (6) months from the date of the denial notice. ( )

04. Conformity. Applicants for certification and certified residential habilitation agencies must conform to all applicable rules of the Department. ( )

05. Inspection of Residential Habilitation Records. The agency and all records required under these rules must be accessible at any reasonable time to authorized representatives of the Department for the purpose of inspection with or without prior notice. Refusal to allow such access may result in revocation of the agency's certificate. ( )

102. DENIAL OF AN APPLICATION.
The Department may deny any application. ( )

01. Causes for Denial. Causes for denial of an application may include: ( )

a. The application does not meet all rule requirements; or ( )

b. The agency does not meet requirements for certification to the extent that it hinders its ability to provide quality services that comply with the rules for residential habilitation agencies; or ( )

c. The application is incomplete; or ( )

d. The applicant, owner, operator, or provider has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; ( )

e. The applicant, owner, operator, or provider has been denied or has had revoked any license or

certificate for a health facility, residential care or assisted living facility, certified family home, or residential habilitation agency; or ( )

f. The applicant, owner, operator, or provider has been convicted of operating a health facility, residential care or assisted living facility, certified family home, or residential habilitation agency without a license or certificate; or ( )

g. A court has ordered that the applicant, owner, operator, or provider must not operate a health facility, residential care or assisted living facility, certified family home, or residential habilitation agency. ( )

h. The Department will not review an application of an applicant who has an action, either current or in process, against a certificate held by the applicant either in Idaho or any other state or jurisdiction. ( )

02. Before Denial is Final. Before denial is final, the Department will advise the individual or provider in writing of the denial and his right and method to appeal. Contested case hearings, including denial and revocation, must be conducted under IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

103. RENEWAL AND EXPIRATION OF CERTIFICATE.
An agency must request, through a Department-approved process, renewal of its certificate no less than ninety (90) days before the expiration date of the certificate, to ensure there is no lapse in certification. ( )

01. Renewal of Certificate. A certificate may be renewed by the Department when it determines the agency requesting recertification is in substantial compliance with the provisions of this chapter of rules. A certificate issued on the basis of substantial compliance is contingent upon the correction of deficiencies in accordance with a plan developed by the agency and approved by the Department. ( )

02. Expiration of Certificate Without Timely Request for Renewal. Expiration of a certificate without a timely request for renewal automatically rescinds the agency's certification to deliver services under these rules. ( )

03. Availability of Certificate. The certificate must be available upon request by the Department, a participant, his guardian, and members of the public. ( )

104. CERTIFICATE NOT TRANSFERABLE.
The certificate is issued only to the agency named in the application, only for the period specified, only for the location indicated in the application, and only to the owners or operators as expressed on the application submitted to the Department. The certificate may not be transferred or assigned to any other person or entity. The certificate is nontransferable from one (1) location to another. ( )

105. RETURN OF CERTIFICATE.
The certificate is the property of the state and must be returned to the state if it is revoked or suspended or voluntarily closed. ( )

106. CHANGE OF OWNERSHIP, ADMINISTRATOR, OR LOCATION.

01. Notification to Department. When a change of ownership, or locations is contemplated, the agency must be recertified and implement the same procedure as an agency that has never been certified. When a change of a certified agency's ownership, administrator, or address is contemplated, the owner or designee must notify the Division of Licensing and Certification in writing through the Department-approved process. ( )

02. New Application Required. In the instance of a change of ownership or lessee the new owner must submit a new application to the Department at least sixty (60) days prior to the proposed date of change. The new application must be submitted to the Division of Licensing and Certification through the Department-approved process and must contain the required information under Section 101.02 of these rules. ( )

107. -- 199. (RESERVED)

200. AGENCY GOVERNING AUTHORITY.
Each agency must be organized and administered under one governing (1) authority. The governing authority may be a named individual or a number of individuals that will assume full legal responsibility for the overall conduct of the agency. ( )

01. Structure. The agency must document an organizational chart that identifies the individuals acting as its governing authority, the administrator, the residential habilitation professional, and all other agency employees with administrative responsibilities. This organizational chart must be provided at the time of the application, updated at lease annually or upon significant change to the agency's organizational structure, and available to the Department upon request. ( )

02. Responsibilities. The governing authority must assume responsibility for: ( )

a. Adopting appropriate organizational bylaws and policies and procedures; ( )

b. Appointing an administrator qualified to carry out the agency's overall responsibilities in relation to written policies and procedures and applicable state and federal laws. The administrator must participate in deliberation of policy decisions concerning all services; ( )

c. Ensuring the agency administrator fulfills the duties and obligations outlined in Section 201 of these rules. Any failure on part of the Administrator is the ultimate responsibility of the agency and its governing body. ( )

d. Conducting and documenting that it performed an annual review of the agency for compliance with these rules; ( )

e. Developing and implementing written administrative policies and procedures that comply with applicable state and federal rules; and ( )

f. Developing and implementing policies and procedures in accordance with these rules. All policies and procedures must be reviewed at least annually and revised as necessary. ( )

201. AGENCY ADMINISTRATOR.
An administrator for an agency is accountable for the overall operations of the agency including ensuring compliance with these rules, overseeing and managing staff, and administering the agency's policies and procedures, and quality assurance program. ( )

01. Administrator Qualifications. Each agency must employ a designated administrator who: ( )

a. Is at least twenty-one (21) years of age; ( )

b. Has satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and ( )

c. Has a minimum of three (3) years of experience in service delivery with the population served with at least one (1) year having been in an administrative role. ( )

02. Absences. The administrator must designate, in writing, a qualified employee to perform the functions of the administrator to act in his absence. This document must be available upon request. ( )

03. Responsibilities. The administrator must: ( )

a. Document and review the overall program and general participant needs on at least a quarterly basis, or more often as necessary, to plan and implement appropriate strategies for meeting those needs; ( )

b. Make all records available to the Department for review or audit; ( )

c. Implement all policies addressing safety measures for the protection of participants and staff as mandated by state and federal rules; ( )

d. Ensure agency personnel, including those providing services, practice within the scope of their certificate or license; ( )

e. Conduct satisfaction surveys at least annually with each participant or guardian, as applicable. ( )

f. Assure training, support services, and equipment for agency staff are provided to carry out assigned responsibilities; ( )

g. Schedule coverage to assure compliance with the Plan of Service and Program Plans. Work schedules reflecting the daily adjustments of employees must be maintained to show the personnel on duty for the scheduled shift. The agency must specify provisions and procedures to assure back-up coverage for those work schedules; and ( )

h. Coordinate with other service providers to assure continuity of the delivery of residential habilitation services in the plan of service. ( )

202. QUALIFICATIONS AND RESPONSIBILITIES OF A RESIDENTIAL HABILITATION PROFESSIONAL.

01. Education and Experience. To be qualified as a residential habilitation professional, a person must: ( )

a. Have at least one (1) year of experience professionally supervised with the population served; and ( )

b. Meet the qualifications of a Qualified Intellectual Disabilities Professional (QIDP) as described in 42 CFR 483.430(a). ( )

c. Experience writing and implementing behavior and skill training program plans; or ( )

i. The agency must provide documentation the employee received such training from an experienced residential habilitation professional; and ( )

ii. Demonstrate the ability to write and implement behavior and skill training program plans. ( )

02. Criminal History and Background Check. A residential habilitation professional must have satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

03. First Aid and CPR Certification. A residential habilitation professional must be certified in first aid and Cardio-Pulmonary Resuscitation (CPR) appropriate for the age of participants he serves prior to providing direct service to participants and maintain current certification thereafter. ( )

04. Responsibilities of a Residential Habilitation Professional. A residential habilitation professional must be employed by the agency on a continuous and regularly scheduled basis. A residential habilitation professional must perform the following: ( )

a. Provide all skill training to agency direct service staff necessary to fulfill each participant's plan of service; ( )

b. Complete or obtain an age appropriate functional assessment for participants served within thirty (30) days of initiation of the service; ( )

c. Develop participant program plans according to the current authorized plan of service for each

participant; and ( )

d. Supervise habilitation services of the agency at least quarterly or more often as necessary to include: ( )

i. The review of direct services performed by direct service staff to ensure that staff are implementing the programs as written and demonstrate the necessary skills to correctly provide the services; and ( )

ii. Monitoring participant progress and documenting changes when necessary to ensure revisions are made for progress, regression, or inability to maintain independence. ( )

05. Direct Service Qualifications. If a residential habilitation professional is providing any type of direct service, he must meet the qualifications of direct service staff as defined in Section 203 of these rules. ( )

203. DIRECT SERVICE STAFF.
Each direct service staff person for an agency must meet all of the following minimum qualifications: ( )

01. Age. Be at least eighteen (18) years of age. ( )

02. Education. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to a plan of service. ( )

03. First Aid and CPR Certification. Be certified in first aid and Cardio-Pulmonary Resuscitation (CPR) appropriate for the age of participants he serves prior to providing direct care or services to participants and maintain current certification thereafter. ( )

04. Health. Have signed a statement maintained by the agency that he is free from communicable disease, understands universal precautions, and follows agency policies and procedures regarding communicable disease. ( )

05. "Assistance with Medications" Course. Each staff person assisting with participant medications must successfully have completed and follow the "Assistance with Medications" course available through the Idaho Division of Career-Technical Education, or other Department-approved training. A copy of the certificate or other verification of successful completion must be maintained by the agency in the employee record. ( )

06. Criminal History Check. Have satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

07. Documentation of Job Description. Have signed and received a copy of his job description from the agency stating that the requirements of his position have been explained. ( )

08. Documentation of Training Requirements. Have documentation maintained by the agency showing he has met all training requirements as outlined in Section 204 of these rules. ( )

204. DIRECT SERVICE STAFF TRAINING.
Each agency must ensure that all staff who provide direct services have completed training in accordance with these rules. ( )

01. Training Documentation. ( )

a. Training documentation must include the following: ( )

i. Direct service staff receiving the training; ( )

ii. Individual conducting the training; ( )

iii. Name of the participant; ( )

iv. Description of the content trained; and ( )

v. Date and duration of the training. ( )

b. Documentation of training must be available for review by the Department, and retained in each employee's record. ( )

02. Orientation Training. Orientation training must be completed prior to working with participants. The orientation training must include: ( )

a. Purpose and philosophy of services; ( )

b. Policies and procedures; ( )

c. Proper conduct in working with participants; ( )

d. Handling of confidential and emergency situations that involve the participant; ( )

e. Participant rights to include personal, civil, and human rights; ( )

f. Universal Precautions; ( )

g. Body mechanics and lifting techniques; ( )

h. Housekeeping techniques; ( )

i. Maintenance of a clean, safe, and healthy environment; and ( )

j. Skills training specific to the needs of each participant served must be provided by a residential habilitation professional and include the following: ( )

i. Instructional techniques including correct and consistent implementation of the participant's program plan or plan of care; ( )

ii. Managing behaviors including techniques and strategies for teaching adaptive behaviors; and ( )

iii. Accurate record keeping procedures. ( )

03. Ongoing Training. The residential habilitation professional must provide and document ongoing training of direct service staff when changes are made to the participant's plan of service and corresponding program plans. Additionally, the agency will be responsible for providing on-going training to direct service staff when there are changes to the participant's physical, medical, and behavioral status. ( )

205. -- 299. (RESERVED)

300. AGENCY POLICIES AND PROCEDURES.
A policy and procedure manual must be developed by the agency to effectively implement its objectives. It must be approved by the governing authority. The manual must, at a minimum, include policies and procedures reflecting the following: ( )

01. Scope of Services and Area Served. The agency must define the scope of services offered and the geographic area served by the agency. ( )

02. Acceptance Standards. The agency must develop and implement written policies and procedures that specify the agency will only accept and retain participants for whom the agency is adequately equipped to

provide appropriate services according to the participant's plan of care. The agency will not accept or retain participants when the agency does not have the personnel appropriate in number and with appropriate knowledge and skill to provide the services needed by each participant according to each participant's plan of care. ( )

03. Participant Records. Each agency must develop and implement written policies and procedures that describe the content, maintenance, and storage of participant records. Each agency must maintain accurate, current, and complete participant records. These records must be maintained for at least five (5) years following the participant's termination of services, or to the extent required by other federal or state requirements. Each agency must have a participant records system to include past and current information and to safeguard participant confidentiality under these rules. ( )

04. Required Services. Each agency must develop and implement written policies and procedures that describe how the agency will assess and provide residential habilitation services. Residential habilitation services consist of an integrated array of individually tailored services and supports. These services and supports are designed to assist the participants to reside in their own homes. Residential habilitation includes 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, and include training in one (1) or more of the following areas: ( )

a. 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; ( )

b. Money management, including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; ( )

c. 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; ( )

d. 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. ( )

i. 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. ( )

ii. Socialization training does not include participation in non-therapeutic activities that are merely diversional or recreational in nature; ( )

e. 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; ( )

f. 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. ( )

g. 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. ( )

h. Skills training conducted by direct service staff to teach the participant how 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. ( )

05. Participant Safety. Each *residential habilitation* agency must develop and implement a policy and procedure for assessing *each individual* participant*'s safety. The assessment must include* environmental and structural risks *to the participant served and how those risks will be reduced or eliminated*. *( )*

06. Disaster/Emergency Care. Each agency must develop and implement emergency planning and care policies and procedures that include situational and environmental emergencies. The policy and procedure must include an emergency preparedness plan to follow in the event of an emergency. ( )

07. Administrative Records. Each agency must maintain all administrative records, including all written policies and procedures, for at least five (5) years or to the extent necessary to meet any other federal or state requirements. Administrative records must include, at a minimum: ( )

a. Administrative structure must include an organizational chart; ( )

b. Legal authority must be identified in organizational bylaws and other documentation of legal authority of ownership; ( )

c. Fiscal records must verify service delivery prior to request for payment. ( )

08. Personnel. Each agency must develop and implement written personnel policies and procedures. The agency is responsible for the recruitment, hiring, training, supervision, scheduling, and payroll for its employees. Written personnel policies that describe the employee's rights, responsibilities, and agency's expectations must be on file and provided to employees. The record must contain documentation supporting staff qualifications. A record for each employee must be maintained from date of hire for not less than five (5) year(s) after the employee is no longer employed by the agency or as necessary to meet other requirements. ( )

09. Participant Rights. Each agency must develop and implement written policies that include a clear definition of personal, civil, and human rights. Upon initiation of services, the agency must provide each participant *and* guardian, *if* applicable, with written and verbal information outlining participant rights. This information must be in easily understood terms. The policy and procedure must include the following rights: *( )*

a. Humane care and treatment; ( )

b. Not be put in isolation; ( )

c. Be free of restraints, unless necessary for the safety of that person or for the safety of others;( )

d. Be free of mental and physical abuse; ( )

e. Voice grievances and recommend changes in policies or services being offered; ( )

f. Have the opportunity to participate in social, religious, and community activities of his choice; ( )

g. Wear his own clothing and retain and use personal possessions; ( )

h. Be informed of his habilitative condition, services available at the agency; ( )

i. Reasonable access to all records concerning himself; ( )

j. *Choose or r*efuse services; *( )*

k. Exercise all civil rights, unless limited by prior court order; ( )

l. Privacy and confidentiality; ( )

m. Receive courteous treatment; ( )

n. Receive a response from the agency to any request made within (14) business days; ( )

o. Receive services that enhance the participant's personal competencies and, whenever possible, promote inclusion in the community; ( )

p. Refuse to perform services for the agency. If the participant is hired to perform services for the agency, the wage paid must be consistent with state and federal law; ( )

q. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction; ( )

r. All other rights established by law; *( )*

s. Be protected from harm*;* *( )*

t. *Choose one's roommate;* *( )*

u. *Reside in the environment or setting that is least restrictive of personal liberties in which appropriate treatment can be provided;* *( )*

v. *Communicate by sealed mail, telephone, or otherwise with persons inside or outside of their residence, to have access to reasonable amounts of letter writing material and postage and to have access to private areas to make telephone calls and receive visitors;* *( )*

w. *Receive visitors at all reasonable times and to associate freely with persons of his own choice;* *( )*

x. *Keep and be allowed to spend a reasonable sum of his own money for personal expenses and small purchases, and have access to individual storage space for his or her own use; and* *( )*

y. *Unless limited to prior court order, exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual arrangements, and vote.* *( )*

10. Health. Each agency must develop and implement written policies and procedures that: ( )

a. Define how the agency will train each direct service staff on procedures to follow for communicable diseases or infected skin lesions; ( )

b. Describe how the agency will protect participants from exposure to individuals exhibiting symptoms of illness; ( )

c. Address any special medical or health care needs specific to each participant; and ( )

d. Implement medication standards and requirements in accordance to Section 302 of these rules. ( )

11. Transportation. Each agency must develop and implement transportation policies that include the following: ( )

a. Preventative Maintenance Program. Establish a preventive maintenance program, including vehicle inspections and other regular maintenance, for all agency-owned vehicles used to transport participants to ensure participant safety. ( )

b. Transportation Safety Policy. Develop and implement a written transportation safety policy. *The policy must include procedures for ensuring adequate staffing of participants who require additional supervision*

during transportation to ensure safety of all vehicle occupants. ( )

c. Licenses and Certifications for Drivers and Vehicles. Obtain and maintain licenses and certifications for drivers and vehicles required by public transportation laws, regulations, and ordinances that apply to the agency to conduct business and to operate the types of vehicles used to transport participants. Agencies must maintain documentation of appropriate licensure for all employees who operate vehicles. ( )

d. Applicable Laws, Rules, and Regulations. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. ( )

e. Liability Insurance. Continuously maintain liability insurance that covers all passengers and meets the minimum liability insurance requirements under Idaho law. If an agency employee transports participants in the employee's personal vehicle, the agency must ensure that adequate liability insurance coverage is carried to cover those circumstances. ( )

12. Quality Assurance. Each agency must develop and implement policies and procedures that describe the Purpose of the Quality Assurance Program that, at minimum, address the components of Section 405 of these rules. ( )

13. Grievance. Each agency must develop and implement policies and procedures that describe the agencies methodology for accepting and responding to grievances presented by participants or their guardians.( )

301. PERSONNEL RECORDS.
The record for each employee must contain at least the following: ( )

01. Name, Current Address, and Phone Number of the Employee; ( )

02. Social Security Number; ( )

03. Education and Experience; ( )

04. Other Qualifications. If licensed in Idaho, the original license number and the date the current registration expires, or if certificated, a copy of the certificate; ( )

05. Date of Employment; ( )

06. Job Description. Documentation that the employee signed and received a copy of his job description stating that the requirements of his position have been explained to him; ( )

07. Date of Termination of Employment and Reason for Termination, If Applicable; ( )

08. Documentation of the Employee's Initial Orientation and Required Training; ( )

09. Evidence of Current Age-Appropriate CPR and First Aid Certifications; ( )

10. Current Assistance With Medications Certification, If Applicable; and ( )

11. Criminal History Check. Verification of satisfactory completion of criminal history checks in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

302. AGENCY MEDICATION STANDARDS AND REQUIREMENTS.
The agency must develop and implement written policy and procedures describing the program's system for handling participant medications that is in compliance with the IDAPA 23.01.01, "Rules of the Board of Nursing." ( )

01. Medication Policy. Each agency must develop written medication policies and procedures that outline in detail how the agency will ensure appropriate handling and safeguarding of medications. An agency that chooses to assist participants with medications to include PRN medications must also develop specific policies and procedures to ensure this assistance is safe and is delivered by qualified, fully-trained staff. Documentation of

training must be maintained in the staff personnel record. ( )

02. Handling of Participant's Medication. ( )

a. The medication must be in the original pharmacy-dispensed container, or in an original over-the-counter container, or placed in a unit container by a licensed nurse and be appropriately labeled with the name of the medication, dosage, time to be taken, route of administration, and any special instructions. Each medication must be packaged separately, unless in a Mediset, blister pack, or similar system. ( )

b. Evidence of the written order for the medication from the physician or other practitioner of the healing arts must be maintained in the participant's record. Medisets, blister pack, or similar system filled and labeled by a pharmacist or licensed nurse can serve as written evidence of the order. An original prescription bottle labeled by a pharmacist describing the order and instructions for use can also serve as written evidence of an order from the physician or other practitioner of the healing arts. ( )

c. The agency is responsible to safeguard the participant's medications when assuming the responsibility for assisting with medications. ( )

d. Medications that are expired or no longer used by the participant must not be retained by the agency or agency staff for longer than thirty (30) calendar days. ( )

03. Self-Administration of Medication. When the participant is responsible for administering his own medication without assistance, a written approval stating that the participant is capable of self-administration must be obtained from the participant's primary physician or other practitioner of the healing arts. The participant's record must also include documentation that a physician or other practitioner of the healing arts, or a licensed nurse has evaluated the participant's ability to self-administer medication and has found that the participant: ( )

a. Understands the purpose of the medication; ( )

b. Knows the appropriate dosage and times to take the medication; ( )

c. Understands expected effects, adverse reactions or side effects, and action to take in an emergency; and ( )

d. Is able to take the medication without assistance. ( )

04. Assistance with Medication. An agency may choose to assist participants with medications; however, only a licensed nurse or other licensed health professional may administer medications. Prior to unlicensed agency staff assisting participants with medication, the following conditions must be in place: ( )

a. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Division of Career-Technical Education, or other Department-approved training; ( )

b. The participant's health condition is stable; ( )

c. The participant's health status does not require nursing assessment, as outlined in IDAPA 23.01.01, "Rules for the Idaho Board of Nursing," before receiving the medication or nursing assessment of the therapeutic or side effects after the medication is taken; ( )

d. The medication is in the original pharmacy-dispensed container with proper label and directions, or in an original over-the-counter container, or the medication has been placed in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container; ( )

e. Written and oral instructions from a licensed physician or other practitioner of the healing arts, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or

side effects, and action to take in an emergency have been reviewed by the staff person; ( )

f. Written instructions are in place that outline required documentation of assistance and who to call if any doses are not taken, overdoses occur, or actual or potential side effects are observed; ( )

g. Procedures for disposal or destruction of medications must be documented and consistent with procedures outlined in the "Assistance with Medications" course or local medication destruction programs. ( )

05. Administration of Medications. Only a licensed nurse or another licensed health professional working within the scope of his license may administer medications. Administration of medications must comply with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

303. AGENCY POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF SOCIAL SKILLS AND MANAGEMENT OF MALADAPTIVE BEHAVIOR.
Each agency must develop and implement written policies and procedures that address the development of participants' social skills and management of maladaptive behavior. These policies and procedures must include statements that address: ( )

01. Adaptive and Maladaptive Behavior. The agency must address possible underlying causes or function of a behavior and identify what the participant may be attempting to communicate by the behavior. ( )

02. Behavior Intervention. Positive behavior interventions must be used prior to and in conjunction with, the implementation of any restrictive intervention. Interventions must address the following: ( )

a. Social Skills Development. Focus on developing or increasing participants' social skills. ( )

b. Prevention Strategies. Ensure and document the use of positive approaches to increase social skills and decrease maladaptive behavior while using least restrictive alternatives and consistent, proactive responses to behaviors. ( )

c. Behavior replacement. Ensure that programs to assist participants with managing maladaptive behavior include teaching of alternative adaptive skills to replace the maladaptive behavior. ( )

d. Protected Rights. Ensure the safety, welfare, and human and civil rights of participants are adequately protected. ( )

e. Objectives and Programs. Ensure that objectives and intervention techniques are developed or obtained and implemented to address self-injurious behavior, aggressive behavior, inappropriate sexual behavior, and any other behaviors that significantly interfere with participants' independence or ability to participate in the community. Ensure that reinforcement selection is individualized and appropriate to the task and not contraindicated for medical reasons. ( )

f. Participant Involvement. Ensure programs developed by the agency involve the participants, to the best of their ability, in developing the plan to increase social skills and to manage maladaptive behavior. ( )

g. Written Informed Consent. Ensure programs developed by an agency to assist participants with managing maladaptive behaviors are conducted only with the written informed consent of the participant, or legal guardian, where applicable. When programs used by the agency are developed by another service provider the agency must obtain a copy of the informed consent. ( )

h. Review and Approval. Programs developed by an agency to manage maladaptive behavior are implemented after the review and written approval of the residential habilitation professional. If the program contains restrictive or aversive components, an individual working within the scope of his license or certification must also review and approve, in writing, the program prior to implementation. When programs implemented by the agency are developed by another service provider, the agency must obtain a copy of these reviews and approvals. ( )

03. Appropriate Use of Interventions. Employees of the agency must not use physical, verbal,

sexual, or psychological abuse, or punishment. For the purposes of these rules, punishment is any procedure in which an adverse consequence is presented that is designed to produce a decrease in the rate, intensity, duration, or probability of the occurrence of a behavior; or, the administration of any noxious or unpleasant stimulus or deprivation of a participant's rights or freedom for the purpose of reducing the rate, intensity, duration, or probability of a particular behavior. Employees of the agency must not withhold food or hydration that contributes to a nutritionally adequate diet. The agency must ensure that interventions used to manage participants' maladaptive behavior are never used: ( )

a. For disciplinary purposes; ( )

b. For the convenience of staff; ( )

c. As a substitute for a needed training program; or ( )

d. By untrained or unqualified staff. ( )

04. Use of Restraint on Participants. No restraints, other than physical restraint in an emergency, must be used on participants prior to the use of positive behavior interventions. The following requirements apply to the use of *physical* restraint on participants: *( )*

a. Physical restraint. ( )

i. Physical restraint may be used in an isolated emergency to prevent injury to the participant or others and must be documented and reviewed in the participant's record by the direct service staff and the residential habilitation professional. *Documentation must include a debrief with the participant and staff involved focusing on strategies to avoid the occurrence of future physical restraints.* *( )*

ii. Physical restraint may be used in a non-emergency setting when a written behavior change plan is developed by the participant *and* his guardian*,* if applicable, his team*,* and a qualified residential habilitation professional. Informed participant consent is required. *( )*

304. -- 399. (RESERVED)

400. AGENCY PARTICIPANT RECORD REQUIREMENTS.
Each agency certified under these rules must maintain accurate, current, and complete participant and administrative records. Each participant record must clearly document the date, time, duration, and type of service, and include the signature of the individual providing the service, for each service provided. Each participant record must contain the following information: ( )

01. Profile Sheet. Each participant record must include a profile sheet containing the following: ( )

a. Name, current address, and current phone number of the participant; ( )

b. Medicaid ID number; ( )

c. Gender and marital status; ( )

d. Date of birth; ( )

e. Names, addresses, and current phone numbers of legal guardian if applicable, family, advocates, friends, and persons to be contacted in case of an emergency; ( )

f. Names, addresses, and current phone number of physician, pharmacy, dentist, and other health care providers as applicable; ( )

g. A list, or an attached list, of current medications, diet, and all other treatments prescribed for the participant; and ( )

h. Current diagnoses or reference to a current history and physical. ( )

02. Authorized Plan of Service. The agency must obtain a current authorized plan of service from the paying entity. ( )

03. Participant Rights. Each agency must document upon initiation of services, that each participant and his guardian, where applicable, have been informed of his rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This information must be provided in easily understood terms both verbally and in writing. ( )

04. History and Physical. Results of a most current history and physical. ( )

05. Functional Assessment. An age-appropriate functional assessment must be completed or obtained by the agency within thirty (30) days of the initiation of service. The functional assessment must be used for the development of program plans and include: *( )*

a. An assessment reflecting the person's functional abilities in the following areas: self-direction, money management, daily living skills, socialization, mobility, behavior shaping, and other therapeutic programs; and ( )

b. The results and summary signed with credentials and dated by the qualified residential habilitation professional. ( )

06. Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment for the purpose of treatment, the results of the assessment must be maintained in the participant's record and used when developing program objectives. ( )

07. Program Plan. Each participant must have a program plan that includes goals and objectives specific to his authorized residential habilitation program. Program plans that include participant's name, baseline statement, measurable objectives, start date, written instructions to staff, service environments, and target date. ( )

08. Record of Significant Incidents, Accidents, Illnesses, and Treatments. ( )

09. Daily Medication Log, When Applicable. ( )

10. Daily Record of the Date, Time, Duration, and Type of Service Provided. ( )

11. Service Delivery and Progress Notes. Documentation of service delivery and progress notes that correspond with the program plans when services are delivered to the participant. ( )

12. Status Review. Residential habilitation agencies must review each participant's progress to ensure revisions are made for progress, regression, or inability to maintain independence. The review of progress must be documented on a status review document. The status review document identifies the participant's progress toward goals defined in the plan of service. ( )

13. Termination Procedures. The agency must develop and implement termination policies and procedures that address how the agency will ensure safety of the participant and community to the extent possible in the event that emergency conditions exist or the participant no longer in need of or desires services. ( )

a. *Emergency conditions warranting termination of services include:* *( )*

i. A change in the participant's condition resulting in an increased level of care beyond the scope of the agency's ability to provide care for the participant. *( )*

ii. Significant behavior concerns including physical aggression by the participant that puts the health and safety of the agency's staff or other participants in jeopardy and behavior management techniques have failed to

reduce the risk to staff or others. *( )*

b. In the instance where the participant is no longer in need of or desires services, the agency must ensure that the procedures include written notice of no less than thirty (30) days for termination*,* include a transition plan*, and a copy of the agency's grievance process*. For the purposes of this chapter, a transition plan is an interim plan developed by the agency defining activities to assist the participant to transition out of residential habilitation services from that agency. *( )*

c. Services may be terminated prior to thirty (30) days if both parties agree in writing to the termination conditions. The agency may not terminate services when to do so would pose a threat of endangerment to the participant or others. The participant is entitled to appeal the termination utilizing the agency's grievance process regardless of the reason for termination. *( )*

d. The agency must notify the participant *and* his guardian*, if applicable,* no less than thirty (30) days prior to a change of ownership to *ensure* informed choice in the services they receive. *( )*

401. -- 402. (RESERVED)

403. PARTICIPANT FINANCES.

01. Written Policy and Procedure. Each agency must develop and implement a written policy and procedure that describes the management of participant funds. In order for an agency to manage participant's funds, they must have written designation as a payee by either Social Security Administration or the participant's guardian or conservator if they are not a recipient of Social Security funds. ( )

02. Participant's Personal Finance Records. When the agency, or its employees or contractors, are designated as the payee on behalf of the participants, the agency must establish and maintain an accounting system that assures a full and complete accounting of participants' personal funds entrusted to the agency, its employees, or contractors on behalf of participants. Records of financial transactions must be sufficient to allow a thorough audit of the participant's funds. An agency that manages participant funds must: ( )

a. Not commingle of participant funds with agency funds. Borrowing between participant accounts is prohibited; ( )

b. Document any financial transactions. A separate transaction record must be maintained for each participant*, including receipts for each expenditure paid for using the participant funds, except for purchases made with participant's personal funds*; *( )*

c. Restore funds to the participant if the agency cannot produce proper accounting records of participant's funds or property; and ( )

d. Provide access to the participant's funds to the participant or his legal guardian or conservator. ( )

e. *Document dispersion of participant personal spending money. Documentation must include the date and amount of the money given to the participant. The participant must acknowledge in writing receipt of the spending money at the time it is dispersed.* *( )*

404. AGENCY REPORTING AND COMMUNICATION REQUIREMENTS.
Each agency must develop and implement written policies and procedures outlining how the agency will document reporting and other communications for the following: ( )

01. Reciprocal Communication. Communication with the legal guardian and other authorized individuals; and ( )

02. Reporting Requirements. Any agency employee or contractor must report all incidents and allegations of mistreatment, abuse, neglect, injuries of unknown origin, or exploitation to the administrator and to

adult protection and law enforcement officials, as required by law under Section 39-5304, Idaho Code. ( )

a. The agency administrator must investigate and document in the participant's records his investigation of all alleged violations. The agency must protect the participant from the possibility of abuse while the investigation is in progress. The administrator must ensure the events and the agency response to the events are documented in the participant record. ( )

b. If the agency administrator verifies the alleged violation, appropriate corrective action must be taken and reported to law enforcement, the Department, and adult protection as required by law under Section 39-5304, Idaho Code. ( )

03. Participant's Condition. The agency administrator must notify the participant's legal guardian within twenty-four (24) hours, if one exists, of any significant incidents, or changes in participant's condition including serious illness, accident, death, or abuse. ( )

04. Notification to Department of a Participant's Condition. Through a Department-approved process, the agency administrator must notify the Department by the close of the next business day of any significant incidents including: death, hospitalization, or if the participant is arrested or incarcerated. The Department will investigate or cause to be investigated any such incident that indicates there was a violation of the rules or statute. ( )

405. AGENCY QUALITY ASSURANCE PROGRAM.
Each agency must develop and implement a quality assurance program. ( )

01. What the Quality Assurance Program Verifies. The quality assurance program is an ongoing, proactive, internal review of the agency designed to verify: ( )

a. Services are provided in accordance with these rules; ( )

b. Sufficient staff are available to meet the needs of each person served; ( )

c. Skill training activities are conducted as written in the program plans. ( )

d. The rights of a person with disabilities are protected and each person is provided opportunities and training to make informed choices. ( )

02. Quality Assurance Program Components. Each agency's written quality assurance program must include: ( )

a. Goals and procedures to be implemented to achieve the purpose of the quality assurance program; ( )

b. Person, discipline, or department responsible for each goal; ( )

c. A system to ensure the correction of problems identified within a specified period of time; ( )

d. A method for assessing participant satisfaction at least annually including minimum criteria for participant response and alternate methods to gather information if minimum criteria is not met; ( )

e. An annual review of agency's policy and procedure manual signed and dated by the administrator that specifies content of revisions made; and ( )

f. An annual review of participant and employee records for complete and current content to meet rules. ( )

406. COMPLAINTS AND INVESTIGATIONS.

01. Filing a Complaint. Any person who believes that the agency has failed to meet any provision of

the rules or statute may file a complaint with the *Division of Licensing and Certification*. All complaints must have a basis in rule or statutory requirements. In the event that it does not, the complainant will be referred to the appropriate entity or agency. *( )*

02. Investigation Survey. The *Division of Licensing and Certification* will investigate, or cause to be investigated the following: *( )*

a. Any complaint alleging a violation of the rules or statute; and ( )

b. Any reportable incident which indicates there was a violation of the rules or statute. ( )

03. Disclosure of Complaint Information. The *Division of Licensing and Certification* will not disclose the name or identifying characteristics of a complainant unless: *( )*

a. The complainant consents in writing to the disclosure; ( )

b. The investigation results in a judicial proceeding and disclosure is ordered by the court; or ( )

c. The disclosure is essential to prosecution of a violation. The complainant is given the opportunity to withdraw the complaint before disclosure. ( )

04. Method of Investigation. The nature of the complaint will determine the method used to investigate the complaint. ( )

05. Statement of Deficiencies. If violations of these rules are identified, depending on the severity, the Department may send the agency a statement of deficiencies. ( )

06. Public Disclosure. Information received by the *Division of Licensing and Certification* through filed reports, inspection, or as otherwise authorized under the law, must not be disclosed publicly in such a manner as to identify individual residents except in a proceeding involving a question of certification. *( )*

07. List of Deficiencies. A current list of deficiencies including plans of correction will be available to the public upon request *in accordance with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )*

08. Notification to Complainant. The *Division of Licensing and Certification* will inform the complainant of the results of the investigation survey when the complainant has provided a name and address. *( )*

407. -- 499. (RESERVED)

500. ENFORCEMENT PROCESS.
The Department may impose a remedy or remedies when it determines an agency is not in compliance with these rules. ( )

01. Determination of Remedy. In determining which remedy or remedies to impose, the Department will consider the agency's compliance history, change of ownership, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to participants. Subject to these considerations, the Department may impose any of the remedies in Subsection 500.02 of this rule, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal. ( )

02. Enforcement Remedies. If the Department determines that an agency is out of compliance with these rules, it may impose any of the following remedies according to Section 500.01 of this rule. ( )

a. Require the agency to submit a plan of correction that must be approved in writing by the Department; ( )

b. Issue a provisional certificate with a specific date for correcting deficient practices; ( )

c. Ban enrollment of all participants with specified diagnoses; ( )

d. Ban any new enrollment of participants; ( )

e. Revoke the agency's certificate; or ( )

f. Summarily suspend the certificate and transfer participants. ( )

03. Immediate Jeopardy. If the Department finds an agency's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may summarily suspend the agency's certificate. ( )

04. No Immediate Jeopardy. If the Department finds that the agency's deficiency or deficiencies do not immediately jeopardize participant health or safety, the Department may impose one (1) or more of the remedies specified in Subsections 500.02.a. through 500.02.e. of this rule. ( )

05. Repeat Deficiencies. If the Department finds a repeat deficiency in an agency, it may impose any of the remedies listed in Subsection 500.02 of this rule as warranted. The Department may monitor the agency on an "as needed" basis, until the agency has demonstrated to the Department's satisfaction that it is in compliance with requirements governing residential habilitation agencies and that it is likely to remain in compliance. ( )

06. Failure to Comply. The Department may impose one (1) or more of the remedies specified in Subsection 500.02 of this rule if: ( )

a. The agency has not complied with any requirement in these rules within three (3) months after the date it was notified of its failure to comply with such requirement; or ( )

b. The agency has failed to correct the deficiencies stated in the agency's accepted plan of correction and as verified by the Department, via resurveys. ( )

501. REVOCATION OF CERTIFICATE.

01. Revocation of the Agency's Certificate. The Department may revoke an agency's certificate when persuaded by the preponderance of the evidence that the agency is not in substantial compliance with the requirements in this chapter of rules. ( )

02. Causes for Revocation of the Certificate. The Department may revoke any agency's certificate for any of the following causes: ( )

a. The certificate holder has willfully misrepresented or omitted information on the application for certification or other documents pertinent to obtaining a certificate; ( )

b. Conditions exist in the agency that endanger the health or safety of any participant; ( )

c. Any act adversely affecting the welfare of participants is being permitted, performed, or aided and abetted by the person or persons supervising the provision of services in the agency. Such acts include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; ( )

d. The provider has demonstrated or exhibited a lack of sound judgment that jeopardizes the health, safety, or well-being of participants; ( )

e. The agency has failed to comply with any of the conditions of a provisional certificate; ( )

f. The agency has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health, safety, or welfare of any participant; ( )

g. An accumulation of minor deficiencies that, when considered as a whole, indicate the agency is not in substantial compliance with these rules; ( )

h. Repeat deficiencies by the agency of any requirement of these rules or of the Idaho Code; ( )

i. The agency lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of participants served at the agency; ( )

j. The agency is not in substantial compliance with the provisions for services required in these rules or with the participants' rights under Subsection 300.09 of these rules; or ( )

k. The certificate holder refuses to allow the Department or protection and advocacy agencies full access to the agency environment, agency records, or the participants. ( )

502. NOTICE OF ENFORCEMENT REMEDY.
The Department will notify the following of the imposition of any enforcement remedy on an agency: ( )

01. Notice to the Agency. The Department will notify the agency in writing, transmitted in a manner that will reasonably ensure timely receipt. ( )

02. Notice to Public. The Department will notify the public by sending the agency printed notices to post. The agency must post all the notices on their premises in plain sight in public areas where they will readily be seen by participants and their representatives, including exits and common areas. The notices must remain in place until all enforcement remedies have been officially removed by the Department. ( )

03. Notice to the Professional Licensing Boards. The Department will notify professional licensing boards, as appropriate. ( )

503. -- 509. (RESERVED)

510. EMERGENCY POWERS OF THE DIRECTOR.
In the event of an emergency endangering the life or safety of a participant receiving services from an agency, the Director may summarily suspend or revoke any residential habilitation certificate. As soon thereafter as practicable, the Director must provide an opportunity for a hearing. ( )

511. INJUNCTION TO PREVENT OPERATION WITHOUT CERTIFICATE.
Notwithstanding the existence or pursuit of any other remedy, the Department may in the manner provided by law, maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of an agency without a certificate required under this chapter. For the purposes of these rules, a governmental unit is the state, or any county, municipality, or other political subdivision, or any department, division, board, or other agency thereof. ( )

512. -- 599. (RESERVED)

600. WAIVERS.
Waivers to these rules may be granted by the Department as needed provided that granting the waiver does not endanger the health or safety or rights of any participant. The decision to grant a waiver is not precedent or given any force or effect of law in any other proceeding. Any waiver granted by the Department may be renewed annually if sufficient written justification is presented to the Department. Waivers granted by the Department must be given in writing and signed by the Department's Licensing and Certification program manager. ( )

601. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.05.03 – RULES GOVERNING CONTESTED CASE PROCEEDINGS AND DECLARATORY RULINGS

DOCKET NO. 16-0503-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2018. The pending rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 and is also adopting a temporary rule. The action is authorized pursuant to Sections 16-107, 56-133, 56-135, 56-202, 56-204A, 56-216, 56-1003, 56-1004, and 56-1005, Idaho Code, 42 CFR Sections 431.221, 431.223, and 431.224.

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 and a statement of any change between the text of the proposed rule and the text of the pending rule:

These rules are being adopted as temporary rules to meet court-ordered settlement agreements for the Jeff D lawsuit, to comply with federal regulations, to provide benefits to consumers, and to provide other needed internal appeals processes for divisional administrative reviews.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice and includes changes made to the pending rule. The text of the pending rule has been modified in accordance with Section 67-5227, Idaho Code. The original text of the proposed rule was published in the September 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 171-180**.

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

The Department needs to have a process for expedited hearings added to meet a settlement agreement ordered by the court. Other changes in this chapter are required for the Department to be in compliance with federal regulations. All changes are being adopted effective January 1, 2018, and confer a benefit for those seeking administrative reviews and hearings.

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 for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending and temporary rule, contact Catherine Libby at (208) 334-0632.

DATED this 16th day of November, 2017.

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 16-107, 56-133, 56-135, 56-202, 56-204A, 56-216, 56-1003, 56- 1004, and 56-1005, Idaho Code, 42 CFR Sections 431.221, 431.22, and 431.224.

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 20, 2017.

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 being made to: meet court-ordered settlement agreements for expedited hearings and grievance processes for the Jeff D settlement agreement, comply with federal regulations, and provide benefits to consumers to use technological advances for filing of appeals for certain divisions, and to provide other needed internal appeals processes for divisional administrative reviews. Several changes are being made to remove and update obsolete language.

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

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

There is no anticipated fiscal impact to the State General Fund or any other funds for this rule change. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking because most of the changes being made are either required by court order, federal regulations, or need to be updated for technology and add divisional appeal processes. The diversity of these changes made it not feasible to hold negotiated rulemaking around the Department's internal appeal processes.

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 Heidi Graham at (208) 334-5617.

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 27, 2017.

DATED this 4th day of August, 2017.

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. 16-0503-1701

005. ADMINISTRATIVE PROCEDURES SECTION.

01. Petitions. Petitions for adoption of rules, and petitions for declaratory rulings, *and appeals* must be filed with: Administrative Procedures Section, 10th Floor, 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036. Phone: (208) 334-5564; FAX: (208) 639-5741; email: APS@dhw.idaho.gov. *(4-11-06)*( )

02. Appeals. Appeals may be filed with the Division, Program, or the Administrative Procedures Section, as provided on the decision notice or in these rules. ( )

006. 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. (4-11-06)

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. (4-11-06)

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (4-11-06)

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (4-11-06)

05. Internet Website. The Department's internet website at http://www.healthandwelfare.idaho.gov/. (4-11-06)

06. Administrative Procedures Section (APS). The following is the contact information for the Administrative Procedures Coordinator: ( )

a. Telephone No.: (208) 334-5564; ( )

b. FAX No.: (208) 639-5741; and ( )

c. E-Mail Address: APS@dhw.idaho.gov. ( )

(BREAK IN CONTINUITY OF SECTIONS)

[SECTION 124 HAS BEEN MOVED AND RENUMBERED TO PROPOSED SECTION 008]

~~124~~ **008. *~~REPRESENTATION~~* ACCESS TO RECORDS OF INDIVIDUALS WITH DEVELOPMENTAL OR MENTAL DISABILITIES.**
*~~Unless an individual, authorized representative or attorney provides a written declaration to the contrary, eligible individuals with developmental disabilities or mental illness are deemed to be represented by t~~*The state Protection and Advocacy System established under 42 USC *~~6041~~* 15041, et seq., and 42 USC 10801 et seq., 29 USC 794e, et seq., and 42 USC 300d as designated by the Governor*~~. The protection and advocacy system~~* has access to records of *~~such~~* individuals who are clients of the system maintained by any program or institution of the Department if the individual has authorized or is unable to authorize the system to have such access, or does not have a legal guardian, conservator or other legal representative. *~~Service of documents will be made on the protection and advocacy system and the individual. Unless the protection and advocacy system provides written notification to the Department that it will not be representing the individual, the system is an authorized representative.~~* *~~(4-11-06)~~*( )

~~008.~~ **009. (RESERVED)**

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of this chapter, the following definitions and abbreviations apply. ( )

01. Administrative Review. An informal review by a Division Administrator or designee, to determine whether a Department decision is correct. (5-8-09)

02. Appellant. A person or entity who files an appeal of Department action or inaction. (3-30-01)

03. Board. The Idaho Board of Health and Welfare. (3-30-01)

04. Complainant. A person or individual who has a grievance regarding Youth Empowerment Services (YES). ( )

05. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. ( )

06. Cost Settlement. Final determinations of payment, based on cost reports, to a Medicaid-enrolled provider. ( )

0*~~4~~*7. Department. The Idaho Department of Health and Welfare. (3-30-01)

0*~~5~~*8. Director. The Director of the Department of Health and Welfare. (3-30-01)

0*~~6~~*9. Hearing Officer. The person designated to preside over a particular hearing and any related proceedings. (3-30-01)

10*~~7~~*. IPV. Intentional program violation. (3-30-01)

***~~08~~*11. Intervenor**. Any person, other than an appellant or the Department, who requests to be admitted as a party in an appeal. (3-30-01)

12. Managed Care Entity (MCE). An entity contracted by Medicaid to administer Medicaid services, which may be a Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), or other Managed Care Organization (MCO) as defined in 42 CFR 438.2. As used in these rules, the term does not include service brokers or entities providing non-emergency medical transportation (NEMT) services. ( )

~~09~~13. **Party**. An appellant, the Department and an intervenor, if intervention is permitted. (3-30-01)

14. Youth Empowerment Services (YES) Program Participant. A YES program participant, is an Idaho resident with a Serious Emotional Disturbance who: ( )

a. Is under the age of eighteen (18); ( )

b. Has a mental health condition described in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and diagnosable by a qualified professional operating within the scope of his practice as defined by Idaho state law; and ( )

c. Has a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified clinician. ( )

d. A substance use disorder or development disorder alone does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis. ( )

(BREAK IN CONTINUITY OF SECTIONS)

101. FILING OF APPEALS.

01. Appeals. Appeals must be filed in writing and state the appellant's name, address and phone number, and the remedy requested, ~~*except that appeals of action relating to Food Stamps may be made verbally to Department staff by an individual or representative*~~ unless otherwise provided in these rules. Appeals should be accompanied by a copy of the decision notice that is the subject of the appeal and state the reason for disagreement with the Department's action. ( )

02. Time Limits for Filing Appeal. Unless otherwise provided by statute or these rules, individuals who are aggrieved by a Department decision have twenty-eight (28) days from the date the decision is mailed to file an appeal. An appeal is filed when it is received by the Department or postmarked within the time limits ~~*set forth*~~ provided in the decision notice, or in these rules. ~~*(5-8-09)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

103. PREHEARING CONFERENCE.

01. Prehearing Conference. The hearing officer may, upon written or other sufficient notice to all interested parties, hold a prehearing conference ~~*to*~~. The purpose of the prehearing conference is to: ( )

a. ~~*f*~~Formulate or simplify the issues; ( )

b. ~~*o*~~Obtain admissions or stipulations of fact and documents; ( )

c. ~~*i*~~Identify whether there is any additional information that had not been presented to the Department with good cause; ( )

d. ~~*a*~~Arrange for exchange of proposed exhibits or prepared expert testimony; ( )

e. ~~*l*~~Limit the number of witnesses; ( )

f. ~~*d*~~Determine the procedure at the hearing; and ~~*to*~~ ( )

g. ~~*d*~~Determine any other matters which may expedite the orderly conduct and disposition of the proceeding. ~~*(3-30-01)*~~( )

02. Exception to Prehearing Conference. The prehearing conference cannot be mandatory for any Division of Welfare *or Division of Medicaid* benefit programs. The following apply: *( )*

a. Participation in the prehearing conference is optional for individuals seeking to appeal for any benefit through the Division of Welfare *or Division of Medicaid*; and *( )*

b. A default order may not be entered for cases in which an individual does not participate in the prehearing conference involving benefits through the Division of Welfare, *or Division of Medicaid*. *( )*

(BREAK IN CONTINUITY OF SECTIONS)

106. DEFAULT.
Unless otherwise provided by statute or rule, ~~I~~if a party fails to appear at a scheduled hearing or at any stage of a contested case, the hearing officer must enter a proposed default order against that party. The default order must be set aside if, within fourteen (14) days of the date of mailing, that party submits a written explanation for not appearing, which the hearing officer finds substantial and reasonable. ~~(4-11-06)~~*( )*

(BREAK IN CONTINUITY OF SECTIONS)

122. FILING OF DOCUMENTS IN AN APPEAL.
All documents intended to be used as exhibits must be filed with the hearing officer. Such documents will be provided to every party at the time they are filed with the hearing officer, in person, ~~or~~ by first class mail, or as otherwise ordered by the hearing officer. Service by mail is complete when the document, properly addressed and stamped, is deposited in the United States or Statehouse mail. A certificate showing delivery to all parties will accompany all documents when they are filed with the hearing officer. ~~(4-11-06)~~*( )*

(BREAK IN CONTINUITY OF SECTIONS)

[SECTION 124 HAS BEEN MOVED AND RENUMBERED TO PROPOSED SECTION 008]

150. REVIEW OF PRELIMINARY ORDERS BY DEPARTMENT.
Unless otherwise provided in these rules, ~~I~~in cases under the jurisdiction of the Department, either party may file a request for review with the Administrative Procedures Section not later than fourteen (14) days from the date the preliminary order was mailed. The request must identify all legal and factual bases of disagreement with the preliminary order. The Director or designee must allow for briefing by the parties and determines whether oral argument will be allowed. The Director or designee determines whether a transcript of the hearing is needed and if so, one will be provided by the party who requests review of the preliminary order. The Director or designee must exercise all of the decision-making power he would have had if he had presided over the hearing. ~~(4-11-06)~~*( )*

(BREAK IN CONTINUITY OF SECTIONS)

199. SPECIFIC CONTESTED CASE PROVISIONS.
The following sections ~~*set forth*~~ of this chapter provide special requirements of various Department divisions or programs~~*, which*~~ that supersede the general provisions of these rules ~~*insofar as*~~ to the extent that they are different ~~*or inconsistent. Sections 200 through 254 pertain to the programs in the Division of Welfare; Sections 300 and 301 pertain to the Division of Medicaid; and Sections 400 through 402 pertain to the Division of Health*~~. ~~*(3-30-01)*~~*( )*

200. DIVISION OF WELFARE: APPEALS.
The provisions of ~~this s~~ Sections 200 through 299 of these rules govern the conduct of individual benefit hearings to determine eligibility for benefits or services in the Division of Welfare~~, including IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families in Idaho," IDAPA 16.03.04, "Rules Governing the Food Stamp Program in Idaho," IDAPA 16.06.12, "Rules Governing the Idaho Child Care Program (ICCP)," IDAPA 16.04.14, "Rules Governing the Low Income Energy Assistance Program," IDAPA 16.04.02, "Idaho Telecommunication Service Assistance Program Rules," IDAPA 16.04.12, "Rules Governing the Individual and Family Grant Program," and IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children."~~ and its programs. ~~(5-8-09)~~( )

01. Division of Welfare Programs. The following programs are covered under the following chapter of rules: ( )

a. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children"; ( )

b. IDAPA 16.03.03, "Rules Governing Child Support Services"; ( )

c. IDAPA 16.03.04, "Rules Governing the Food Stamp Program in Idaho"; ( )

d. IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)"; ( )

e. IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families in Idaho"; ( )

f. IDAPA 16.04.14, "Rules Governing the Low Income Energy Assistance Program"; ( )

g. IDAPA 16.04.02, "Idaho Telecommunication Service Assistance Program Rules"; ( )

h. IDAPA 16.04.12, "Rules Governing the Individual and Family Grant Program"; and ( )

i. IDAPA 16.06.12, "Rules Governing the Idaho Child Care Program (ICCP)." ( )

02. Methods for Filing Appeals. Requests for appeals may be made with the Division of Welfare as provided in Section 006 of these rules, using any one (1) of the following listed in this subsection: ( )

a. Via the Department's internet website: ( )

b. By telephone; ( )

c. Via mail; ( )

d. In person; and ( )

e. Other commonly available electronic means. ( )

201. DIVISION OF WELFARE: TIME FOR FILING APPEAL.
A decision issued by the Department in a Division of Welfare benefit program will be final and effective unless an individual or representative appeals within thirty (30) days from the date the decision was mailed, except that a recipient or applicant for Food Stamps has ninety (90) days to appeal. An individual or representative may also appeal when the Department delays in making an eligibility decision or making payment beyond the limits specified in the particular program within thirty (30) days after the action would have been taken if the Department had acted in a timely manner. ~~(5-8-09)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

203. DIVISION OF WELFARE: WITHDRAWAL OF AN APPEAL.
An appellant or representative may withdraw an appeal upon ~~written~~ request to the hearing officer using any one (1) of the methods listed in Section 200 of these rules. ~~(5-8-09)~~( )

204. DIVISION OF WELFARE: TIME LIMITS FOR COMPLETING HEARINGS.
The Department must conduct the hearing relating to an individual's benefits and take action within ninety (90) days from the date the hearing request is received, unless as provided in Subsections 204.01 through 204.03 of this rule. ( )

01. Community Spouse Resources Allowance. When the hearing request concerns the computed amount of the Community Spouse Resource Allowance, the hearing will be held within thirty (30) days from the date the hearing request is received. ( )

02. Food Stamps. When the hearing relates to Food Stamps, the hearing, the decision of the hearing, and the notice regarding the outcome of the hearing will be completed within sixty (60) days from the date the hearing request is received. ( )

03. Expedited Hearings. The Department will expedite hearing requests from appellants ~~such as~~ for the following reasons: ( )

a. ~~m~~Migrant farm workers who are planning to move before the hearing decision would normally be reached~~.~~; or ~~(5-8-09)~~( )

b. Individuals requesting an expedited fair hearing will be provided a hearing as required according to 42 CFR 431.224. ( )

(BREAK IN CONTINUITY OF SECTIONS)

298. DIVISION OF WELFARE: ~~BUREAU OF~~ CHILD SUPPORT SERVICES.
~~A notice of license suspension becomes final and effective unless~~ In a child support enforcement proceeding, an individual or a representative ~~files an appeal within twenty-one (21) days from the date the decision is mailed~~ may request a hearing after being served notice of license suspension or notice of an asset withholding order from the Financial Institution Data Match (FIDM) process. ~~(5-8-09)~~( )

01. Time Limits for Requesting a Hearing. ( )

a. License Suspension. The licensee has twenty-one (21) days from the date of service of the notice either by personal service or certified mail, to request a hearing by filing with the Department to contest the suspension of license or licenses. A timely request for a hearing stays the suspension of the license or licenses through the issuance of the order by the Department. The Department will notify the licensing authority if the suspension is vacated or stayed. ( )

b. Financial Institution Data Match (FIDM). The obligor or co-owner has fourteen (14) days from the date of mailing the notice of asset withholding order to request a hearing in writing to contest the asset being withheld. Upon receiving a timely request for hearing, the Department will notify the financial institution that it must continue to hold the asset until an order is issued and the Department provides instructions for the disposition of the asset. If the obligor or co-owner does not file a timely request for hearing, the Department will notify the financial institution to promptly surrender the amount of the asset that has been frozen to the Department. ( )

02. Time Limits for Completing Hearings. The Department will hold an administrative hearing within thirty (30) days from the day the Department receives the request for hearing to contest asset withholding from the FIDM process. ( )

03. Default. ( )

a. Licensing Authority. If the licensee fails to make a timely request for a hearing or fails to appear at the hearing without good cause, the Department will issue an order of Default suspending the license or licenses. On receipt of the final order from the Department, the licensing authority will suspend the license effective the date the order became final, without additional review or hearing. ( )

b. Financial Institution. If the obligor or co-owner of the asset fails to appear at the hearing without good cause, the Department will issue an order of Default upholding the asset withholding order. On receipt of the final order from the Department, the financial institution will promptly surrender the amount of the asset that has been frozen to the Department. ( )

04. Time for Filing an Appeal. An order of suspension or asset withholding order issued by a hearing officer of the Department will be final and conclusive between the parties unless a petition for review is filed within twenty-eight (28) days with the district court. ( )

299. (RESERVED)

300. DIVISION~~S~~ OF MEDICAID ~~AND LICENSING AND CERTIFICATION~~: ~~REQUEST FOR~~ ADMINISTRATIVE REVIEWS FOR PROVIDERS AND FACILITIES.

01. Written Request. An action relating to ~~licensure or certification, billing or reimbursement~~ audited cost reports or Medicaid cost settlement calculations required by administrative rule is final and effective unless the provider or facility requests in writing an administrative review within ~~twenty-eight~~ thirty (~~28~~30) days after the notice is mailed. The request must: ( )

a. ~~b~~Be signed by the licensed administrator of the facility or by the provider~~,~~; ( )

b. ~~i~~Identify the challenged decision~~, and~~; ( )

c. ~~s~~State specifically the grounds for its contention that the decision was erroneous; and ( )

d. Include copies of any documentation on which the facility or provider intends to rely to support its position. ( )

02. Review Conference. The parties must clarify and attempt to resolve the issues at the review conference, which must be held within ~~twenty-eight~~ thirty (~~28~~30) days after the request for the administrative review is received. The thirty (30) day requirement may be extended when both parties agree in writing to a specified later date. If the Department determines that additional documentation is needed to resolve the issues, a second session of the conference may be scheduled within thirty (30) days of the initial conference. This second session date may be extended when both parties agree in writing to a specified later date. ( )

03. Department Decision. The Department will provide a written decision to the facility or provider. ~~(5-8-09)~~( )

301. DIVISION~~S~~ OF MEDICAID ~~AND LICENSING AND CERTIFICATION~~: SCOPE OF APPEAL HEARING.
If the Department's decision after the administrative review is appealed, only issues and documentation that were presented in the administrative review will be admissible in the appeal hearing. ~~(4-11-06)~~( )

302. DIVISION OF MEDICAID: APPEALS PROCESS FOR MEDICAID PARTICIPANTS.

01. Medicaid Participant Appeals. Medicaid participants whose appeals are not related to services delivered through a Managed Care Entity (MCE), as defined in Section 010 of these rules, must use the appeals process provided in Sections 101 through 1~~9~~99 of these rules. ( )

02 Medicaid Participant Appeals Related to Services Delivered Through Managed Care Entity. ( )

a. Participants whose appeals are related to services delivered through a managed care entity must utilize the complaint, grievance, and appeal process required by the Department and the managed care contractor. ( )

b. Participants whose appeals are related to services delivered through a Managed Care Entity (MCE) must follow the appeals process in 42 CFR 438.402 through 42 CFR 438.408. ( )

03. Expedited Fair Hearings for Medicaid Participants. The Department will provide a process for expedited fair hearings for Medicaid participants in accordance with 42 CFR *Part* 438 *or 431, as applicable*. ( )

302~~2~~3. -- 399. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

504. -- ~~9~~599. (RESERVED)

600. DIVISION OF LICENSING AND CERTIFICATION: REQUEST FOR ADMINISTRATIVE REVIEW.

01. Written Request. An action relating to licensure or certification is final and effective unless the provider or facility requests in writing an administrative review within twenty-eight (28) days after the notice is mailed. The request must: ( )

a. Be signed by the licensed administrator of the facility, or by the provider; ( )

b. Identify the challenged decision; and ( )

c. State specifically the grounds for its contention that the decision was erroneous. ( )

02. Review Conference. An administrative review conference must be held within twenty-eight (28) days of receipt of the request for the administrative review. The twenty-eight (28) day requirement may be extended when both parties agree in writing to a specified later date. The parties must clarify and attempt to resolve the issues during the administrative review conference. If the Department determines additional documentation is needed to resolve the issues, a second session of the review conference may be scheduled. ( )

03. Department Decision. The Department will provide a written decision to the facility or provider within thirty (30) days of the conclusion of the administrative review conference. ( )

601. -- 699. (RESERVED)

700. DIVISION OF BEHAVIORAL HEALTH: REQUEST FOR ADMINISTRATIVE REVIEW.

01. Written Request. An action relating to program approval is final and effective unless the provider or facility requests in writing an administrative review within twenty-eight (28) days after the notice is mailed. The request must: ( )

a. Be signed by the program administrator of the facility; ( )

b. Identify the challenged decision; and ( )

c. State specifically the grounds for its contention that the decision was erroneous. ( )

02. Review Conference. The parties must clarify and attempt to resolve the issues at the review conference, which must be held within twenty-eight (28) days after the request for the administrative review. The twenty-eight (28) day requirement may be extended when both parties agree in writing to a specified later date. If the

Department determines that additional documentation is needed to resolve the issues, a second session of the conference may be scheduled. ( )

03. Department Decision. The Department will provide a written decision to the facility or provider within thirty (30) days of the conclusion of the administrative review conference. ( )

701. -- 749. (RESERVED)

750. DIVISION OF BEHAVIORAL HEALTH: YOUTH EMPOWERMENT SERVICES (YES).
Contested case proceedings for non-Medicaid Youth Empowerment Services (YES) are governed by the general provisions of this chapter, unless otherwise specified in Section 751 of these rules. ( )

751. DIVISION OF BEHAVIORAL HEALTH: YOUTH EMPOWERMENT SERVICES (YES) GRIEVANCE PROCESS.

01. Grievance. Individuals, family members, or legal guardians may choose to submit a written request to participate in this grievance process regarding non-Medicaid matters related to YES services. A grievance is a statement of dissatisfaction about any matter other than an adverse benefit determination. ( )

02. Grievance Content. A grievance must include: ( )

a. The full name, mailing address, phone numbers, and e-mail contact for the individual who is the complainant using YES services; ( )

b. The full name, mailing address, phone numbers, and e-mail contact of the person submitting the grievance on behalf of the complainant; ( )

c. A detailed explanation of the decision or non-Medicaid matter related to YES services that is being contested from the perspective of the complainant; and ( )

d. Any steps that have already been taken to resolve the issue. ( )

03. Department Response to Grievance. The Department will respond to the complainant within sixty (60) days of receipt of the grievance on its findings. The grievance process may include gathering additional information from involved parties and may run concurrent to the fair hearing process. ( )

a. The Department will address concerns related to dissatisfaction with a process or a provider at the lowest or most appropriate organizational level possible. ( )

b. The Department will document the filing of the grievance and the outcome in its response to the complainant. ( )

04. Expedited Hearings. *When t*he Division of Behavioral Health *determines that an expedited fair hearing is needed using the same standards described in Section 302 of these rules, the Department* will provide *an* expedited *fair* hearing for non-Medicaid eligible YES individuals in compliance with *time limits for an agency found in* 42 CFR 431 *for YES inpatient services,* or *the time limits for a PAHP found in 42 CFR* 438, *for outpatient YES services*. ( )

752. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.05.07 – THE INVESTIGATION AND ENFORCEMENT OF FRAUD, ABUSE, AND MISCONDUCT

DOCKET NO. 16-0507-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the 2018 legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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(b), 56-203(1) & (2), 56-209h, 56-227, 56-227A through D, 56-1001, and 56-1003, Idaho Code, as well as 42 CFR 1002.214 and 1002.215.

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 amendments to these rules align ownership or control interest with percentages and definitions with other existing state rules and federal definitions. Payment suspensions under federal regulations can be suspended without first notifying a Medicaid provider of the intention to do so under certain circumstances and these rules are amended to allow the Department to do so.

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 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 313-316**.

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 state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Lori Stiles at (208) 334-0653.

DATED this 3rd day of November, 2017.

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 PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(1) & (2), 56-209h, 56-227, 56-227A through D, 56-1001, and 56-1003, Idaho Code, and 42 CFR 1002.214 and 1002.215.

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 18, 2017.

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 amendments to these rules are to align ownership or control interest with percentages and definitions with other existing state rules and federal definitions. Payment suspensions under federal regulations can be suspended without first notifying a Medicaid provider of the intention to do so under certain circumstances and these rules are being amended to allow the Department to do so. This ability was inadvertently removed from the rule when other public assistance providers were added to these rules in 2014. Medicaid providers will continue to receive notification of payment suspensions under federal requirements in 42 CFR455.23(b).

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

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

There is no anticipated fiscal impact to state general funds or any other funds except the costs of the rule promulgation, which includes printing and publication. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking as this rule change aligns with federal regulations and other Department rules.

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 Lori Stiles at (208) 334-0653.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0507-1701

010. DEFINITIONS AND ABBREVIATIONS.
For purposes of this chapter of rules, the following terms apply. (3-20-14)

01. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, child care, or medical practices, and result in an unnecessary cost to a public assistance program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a medical assistance recipient. (3-20-14)

02. Access to Documentation and Records. To review and copy records at the time a written request is made during normal business hours. Documentation includes all materials as described in Section 101 of these rules. (3-30-07)

03. Claim. Any request or demand for payment, or document submitted to initiate payment, for items or services provided under a public assistance program, whether under a contract or otherwise. (3-20-14)

04. Conviction. An individual or entity is considered to have been convicted of a criminal offense: (3-30-07)

a. When a judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (3-30-07)

b. When there has been a finding of guilt against the individual or entity by a federal, state, or local court; (3-30-07)

c. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court; or (3-30-07)

d. When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. (3-30-07)

05. Department. The Idaho Department of Health and Welfare, its authorized agent or designee. (3-30-07)

06. Exclusion. A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. (3-30-07)

07. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. (3-30-07)

08. Knowingly, Known, or With Knowledge. A person, with respect to information or an action, who: (3-20-14)

a. Has actual knowledge of the information or an action; (3-20-14)

b. Acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or (3-20-14)

c. Acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (3-20-14)

09. Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. (3-30-07)

10. Medicaid. Idaho's Medical Assistance Program. (3-30-07)

11. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

12. Ownership or Control Interest. A person or entity that: (3-20-14)

a. Has an ownership interest totaling ~~*twenty-*~~five percent (~~*2*~~5%) or more in an entity; ~~*(3-20-14)*~~( ) (3-20-14)

b. Is an officer or director of an entity that is organized as a corporation; (3-20-14)

c. Is a partner in an entity that is organized as a partnership; or (3-20-14)

d. Is a managing member in an entity that is organized as a limited liability company. (3-20-14)

13. Participant. An individual or recipient who is eligible and enrolled in any public assistance program. (3-20-14)

14. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (3-30-07)

15. Program. Any public assistance program, including the Medicaid program and Idaho's State Plan, or any parts thereof. (3-20-14)

16. Provider. An individual, organization, agency, or other entity providing items or services under a public assistance program. (3-20-14)

17. Provider Agreement. A written agreement between the Department and a provider or group of providers of supplies or services. This agreement contains any terms or conditions deemed appropriate by the Department. (3-30-07)

18. Public Assistance Program. Assistance for which provision is made in any federal or state law existing, or hereafter enacted, by the state of Idaho or the congress of the United States by which payments are made from the federal government to the state in aid, or in respect to payment by the state for welfare purposes to any category of needy person, and any other program of assistance for which provision for federal or state funds for aid may from time to time be made. (3-20-14)

19. Recoup and Recoupment. The collection of funds for the purpose of recovering overpayments made to providers for items or services the Department has determined should not have been paid. The recoupment may occur through the collection of future claims paid or other means. (3-30-07)

20. Sanction. Any abatement or corrective action taken by the Department which is appealable under Section 003 of these rules. (3-30-07)

21. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-30-07)

22. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-30-07)

23. Title XXI. Title XXI of the Social Security Act, known as the Children's Health Insurance Program

(CHIP). This is a program that primarily pays for medical assistance for low-income children. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

210. SUSPENSION OF PAYMENTS PENDING INVESTIGATION.
The Department may suspend public-assistance payments in whole or part in a suspected case of fraud or abuse pending investigation and conclusion of legal proceedings related to the provider's alleged fraud or abuse. When payments have been suspended under this section of rule, the Department will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal. (3-20-14)

01. Basis for Suspension of Payments. When the Department through reliable evidence suspects fraud or abuse, or when a provider fails to provide immediate access to records, public-assistance payments may be withheld or suspended. (3-20-14)

02. Notice of Suspension of Payments. The Department may ~~not~~ withhold public-assistance payments without first notifying the provider of its intention to do so when the Department is suspending payments of a Medicaid provider. The Department will send written notice within five (5) days of taking such action in accordance with 42 CFR 455.23(b). All other public assistance providers will be notified prior to the suspension of payments.
~~(3-20-14)~~( )

03. Duration of Suspension of Payments. The withholding of payment actions under this section of rule will be temporary and will not continue after: (3-30-07)

a. The Department or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider; or (3-30-07)

b. Legal proceedings related to the provider's alleged fraud or abuse are completed. (3-30-07)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.01 – CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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; and Senate Bill 1164 (2017).

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 puts into rule the specific increases to the foster care reimbursement rates that reflect the corresponding appropriation by the 2017 legislature. The rule changes represent a 20% increase in the foster care reimbursement rates.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 5, 2017, Idaho Administrative Bulletin, **Vol. 17-7, pages 58 and 59**.

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:

$839,100 ($347,800 general funds and $491,300 federal fund authority) was appropriated by the 2017 legislature to provide for a 20% increase to the foster care reimbursement rates. These increased rates will help foster parents provide shelter, food, clothing, supervision, educational necessities, and other personal incidentals required to promote the safety and well-being of the children in their care.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sabrina Brown at (208) 334-5648.

DATED this 16th day of November, 2017.

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 PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2017.

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: 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; and Senate Bill 1164 (2017).

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 19, 2017.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking puts into rule the specific increases to the foster care reimbursement rates that reflect the corresponding appropriation by the 2017 legislature. The rule changes represent a 20% increase in the foster care reimbursement rates.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule confers a benefit as it provides for the increase of the monthly foster care reimbursement rates.

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

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

$839,100 ($347,800 general funds and $491,300 federal fund authority) was appropriated by the 2017 legislature to provide for a 20% increase to the foster care reimbursement rates. These increased rates will help foster parents provide shelter, food, clothing, supervision, educational necessities, and other personal incidentals required to promote the safety and well-being of the children in their care.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was deemed not feasible as these rule changes simply serve to put into place the increase to the monthly foster care reimbursement rates that reflect the funds appropriated by the 2017 legislature. Further negotiation over this rule change is not an option as any additional increase would require approval by the Idaho legislature.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sabrina Brown at (208) 334-5648.

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 26, 2017.

DATED this 9th day of June, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0601-1701

483. PAYMENT TO FAMILY ALTERNATE CARE PROVIDERS.
Monthly payments for care provided by family alternate care providers are:

Family Alternate Care Payments - Table 483			
Ages	0-5	6-12	13-18
Monthly Room and Board	$3~~29~~95	$~~366~~439	$~~487~~584

~~(3-20-14)~~( )

01. Gifts. An additional thirty dollars ($30) for Christmas gifts and twenty dollars ($20) for birthday gifts will be paid in the appropriate months. (5-8-09)

02. Clothing. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. (5-8-09)

03. School Fees. School fees due upon enrollment will be paid directly to the school or to the alternate care providers, based upon the Department's determination of the child's needs. (5-8-09)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.01 – CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-1702

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 following: 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; 45 CFR 1356.21-22, 45 CFR 1356.30, 45 CFR 233.90(b)(2); Sections 471, 472, and 479B of the Social Security Act; and Sections 403, 431, and 432 of the Personal Responsibility Work Opportunity Reconciliation 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 the requirements for Title IV-E funding for children in foster care with current CFR and federal 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 September 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 181 through and 187**.

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 for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Carissa Decker at (208) 334-0692.

DATED this 16th day of November, 2017.

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 PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that proposed rulemaking procedures have been initiated. The action is authorized pursuant to the following: 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; 45 CFR 1356.21-22, 45 CFR 1356.30, 45 CFR 233.90(b)(2); Sections 471, 472, and 479B of the Social Security Act; and Sections 403, 431, and 432 of the Personal Responsibility Work Opportunity Reconciliation Act.

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

PUBLIC HEARING
Wednesday, September 20, 2017 – 9:00 a.m.

DHW Central Office
450 West State Street
5th Floor, Conference Room A
Boise, ID 83720

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

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

This rulemaking aligns the requirements for Title IV-E funding for children in foster care with current CFR and federal law.

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

FISCAL IMPACT: The following is a specific description, if applicable, of any 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 for this rule change. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was determined not feasible as these rules are simply being aligned with federal requirements in 45 CFR 1356.21 (Foster care maintenance payments program implementation requirements) and Section 472 of the Social Security Act (Foster Care Maintenance Payments Program), so there is nothing to negotiate.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Carissa Decker at (208) 334-0692.

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 27, 2017.

DATED this 4th day of August, 2017.

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. 16-0601-1702

425. ~~*AID TO FAMILIES WITH DEPENDENT CHILDREN -- FOSTER CARE (AFDC-FC)*~~ TITLE IV-E ELIGIBILITY.

~~*A child is eligible for Aid To Families With Dependent Children-Foster Care (AFDC-FC) if the child would have been eligible to receive AFDC aid payments except that he was removed, by court order, from the home of a parent(s) or other caretaker relative(s) and placed in foster care. AFDC-FC is also available to eligible children voluntarily placed in foster care by a parent(s). The caretaker relative(s) is the relative(s) who exercises day-to-day physical custody of the child prior to the court action or voluntary placement. The child may qualify for AFDC payments as a child living with a relative. Eligibility for AFDC-FC is determined by Family and Community Services.~~* The state will claim Title IV-E funding for a foster child who meets the following criteria: ~~*(4-6-05)*~~( )

01. Physical or Constructive Removal of the Child. The child was physically or constructively removed from the home: ( )

a. Under a voluntary placement agreement; or ( )

b. As the result of a judicial determination that: ( )

i. Remaining in the home would be contrary to the child's welfare; or ( )

ii. Placement in foster care would be in the best interest of the child. ( )

c. The determination that a situation is contrary to the child's welfare must be made in the first court ruling that sanctions, even temporarily, the removal of a child from the home. ( )

02. Child's Residence. The child has been living in the home of a parent or other relative specified at 45 CFR 233.90(c)(1)(v) either in the month of, or within six (6) months prior to the month: ( )

a. Removal court proceedings were initiated; or ( )

b. The voluntary placement agreement was signed. ( )

03. AFDC Eligibility. The child was AFDC (Aid to Families with Dependent Children) eligible in the removal home during the month of the initiation of court proceedings that initiated the removal or the month the voluntary placement agreement is signed. AFDC eligibility is based upon the standards found in the State's IV-A Plan on July 16, 1996. ( )

04. "Removal From" and "Living With" Requirements. The "removal from" (01. of this rule) and "living with" (02. of this rule) requirements must be satisfied by the same specified relative who meets AFDC eligibility (03. of this rule). ( )

05. Judicial Determination. A judicial determination was obtained regarding reasonable efforts to prevent a child's removal from the home no later than sixty (60) days from the child's foster care entry date. When there is a judicial determination of "aggravated circumstances," the court order must state that no reasonable efforts to reunify the family are required. ( )

06. Agency with Placement Care and Responsibility. The IV-E agency, or another public agency or Tribe that has a plan approved under 42 U.S.C. 671 in accordance with 42 U.S.C. 679c with which the Title IV-E agency has a written agreement in effect, has placement and care responsibility. ( )

07. Child in Foster Care or Childcare Institution. The child is in a fully licensed or approved foster family home, or childcare institution. ( )

08. Compliance with Safety Requirements. Compliance with the safety requirements was documented for the prospective foster family home or childcare institution. ( )

09. Child's Age. The child is under the age of eighteen (18), or up to age nineteen (19) if the youth is a full-time student in a secondary school or its equivalent level of vocational or technical training and is expected to complete the educational program before reaching age nineteen (19). ( )

10. Child's Citizenship Status. The child is a US citizen or qualified immigrant under Sections 403, 431, and 432 of the Personal Responsibility Work Opportunity Reconciliation Act (P.L. 104-193. ( )

426. ~~AFDC-FC ELIGIBILITY REQUIREMENTS.~~ (RESERVED)

~~A child is eligible for AFDC-FC if he meets each of the eligibility requirements listed in Table 426.~~

~~AFDC-FC ELIGIBILITY REQUIREMENTS -- TABLE 426~~		
	~~CONDITION~~	~~DESCRIPTION~~
~~01.~~	~~Financial Need.~~	~~A child is in financial need if, in the month court action to remove him from his home was initiated, or the month the voluntary out-of-home placement agreement is signed:~~ ~~He was receiving AFDC;~~ ~~He would have been eligible to receive AFDC if an application had been filed on his behalf; or~~ ~~He lived with his parent(s) or other caretaker relative(s) at some time within six (6) prior months and would have qualified for AFDC in the month of court action or voluntary placement if an application had been filed and he lived with a parent(s) or other specified relative(s) in that month.~~
~~02.~~	~~Voluntary Placement in Foster Home or Voluntary Relinquishment.~~	~~A foster care placement is voluntary if the parent(s) has a written voluntary services agreement with the Department to place the child in foster care. The parent retains parental rights and may terminate the agreement at any time.~~ ~~A voluntary relinquishment is not a voluntary placement. A voluntary relinquishment occurs when parent(s) permanently gives up rights to a child. A court order is required for a voluntarily relinquished child to qualify for AFDC-FC.~~
~~03.~~	~~Age, Residence, Citizenship, and Deprivation.~~	~~The other AFDC requirements the child must meet are:~~ ~~Age;~~ ~~Residence;~~ ~~Citizenship;~~ ~~Deprivation; and~~ ~~The AFDC resource limit.~~

AFDC-FC ELIGIBILITY REQUIREMENTS -- TABLE 426		
CONDITION		DESCRIPTION
04.	Court Ordered Removal.	A child not voluntarily placed must have been removed from the parent(s) or other caretaker relative(s) by court order. The initial court order must state remaining in the home would be "contrary to the welfare" of the child. For children removed on or after October 1, 1983, the court order must include a determination that reasonable efforts were made to prevent or eliminate the need for removal of the child. This judicial determination must be made within sixty (60) days of removal of the child from his home. The court order must state what reasonable efforts were made considering the family's circumstances and the safety of the child when the child is removed from the home in an emergency. When there is a judicial determination of Aggravated Circumstances, the court order must state that no reasonable efforts to reunify the family are required.
05.	Custody and Placement.	The child's placement and care are the Department's responsibility. The child must live in a licensed foster home, licensed institution, licensed group home, or in a licensed relative's home.

(5-8-09)

427. DETERMINATION OF ELIGIBILITY FOR ADC-FC TITLE IV-E.
The family services workers must initiate submit an application to ensure that eligibility for ADC-FC is made, or that the child is clearly ineligible because of family resources. The worker must maintain documentation of the eligibility determination or ineligibility in the case record of the child, and arrangements for parental support the Child Welfare Funding Team to evaluate for Title IV-E eligibility. If the child is ineligible for AFDC-FC, the family services worker must determine whether the child qualifies for Medicaid as a Title XIX foster child. (5-8-09)( )

428. CUSTODY AND PLACEMENT.
The child's placement and care are the Department's responsibility. The child must live in a licensed foster home, licensed institution, licensed group home, or in a licensed relative's home. (3-30-01)

01. Interstate Placements. In interstate placements, a child may be placed with an approved unlicensed relative when delaying the placement would be harmful to the child's well-being. In those cases, a subsequent request for foster care licensure will be made through the Interstate Compact on the Placement of Children. However, in these instances, a child is ineligible for Title IV-E until the placement is licensed.
(3-30-07)( )

02. Intrastate Placements That Become Interstate Placements. If a foster care placement that was initially intrastate becomes an interstate placement because the family with whom the child is placed relocates to another state, a request for foster care licensure will be made through the Interstate Compact on the Placement of Children immediately upon the decision to move the child. If the state to which the family has moved accepts the family's Idaho foster care license as effective, the placement is considered licensed until a determination is made that the family is in compliance with the licensing and other applicable laws of the state to which the family has moved.
(3-30-07)

429. EFFECTIVE DATE.
AFDC-FC eligibility can Claims for Title IV-E maintenance may begin as early as the first day of placement in the month in which all initial Title IV-E eligibility factors are met. with the following exceptions: A child cannot receive AFDC and AFDC-FC or SSI and AFDC-FC in the same month; and AFDC-FC cannot begin until the month after

~~the last month the child's needs were included in an AFDC grant or the child received SSI~~ Title IV-E foster maintenance payments during the same time period. ~~(3-30-01)~~( )

430. ONGOING ELIGIBILITY.
To continue eligibility for ~~AFDC FC~~ Title IV-E, a child must meet ~~each of the eligibility~~ the following conditions ~~listed in Table 430.~~:

~~CONTINUING ELIGIBILITY CONDITIONS, TABLE 430~~

~~CONDITION~~		~~DESCRIPTION~~
~~01.~~	~~Financial Need.~~	~~The child's own income, after any applicable AFDC income exclusions and disregards, must not exceed the foster care need standard established for him by the Department.~~
~~02.~~	~~AFDC Factors.~~	~~The child must continue to meet the following AFDC eligibility factors. Age; Residence; Citizenship; Resource limits; and Deprivation. (A child who has been removed from the home of a caretaker relative who is not his parent, meets the deprivation requirement without review.)~~
~~03.~~	~~Ongoing Custody and Placement.~~	~~The child must remain in the Department's custody through either a current court order or a voluntary placement agreement that has not been in effect more than one hundred and eighty (180) days. They must continue to live in a licensed foster home, licensed institution, licensed group home, or a licensed relative's home.~~
~~04.~~	~~Redetermination.~~	~~The child's eligibility for AFDC-FC must be redetermined at least once every six (6) months.~~ ~~A redetermination, rather than an initial eligibility determination, is used for a child who left foster care, was placed in a non-AFDC-FC living situation such as a hospital or detention center, did not return home, remained in the Department's custody throughout his absence, and returned to foster care.~~ ~~Any return home other than a visit requires a new judicial determination or a new agreement and a new determination of eligibility based on current circumstances.~~ ~~Annual Review: An annual redetermination is required to assure that the court has determined that the Department has made reasonable efforts to finalize a permanent plan for the child. This is done at the Permanency Hearing held every twelve (12) months from the date of removal until the child is either adopted or placed in legal guardianship.~~ ~~The foster care payment standard is also the child's eligibility income limit for determining continued eligibility for AFDC-FC.~~

CONTINUING ELIGIBILITY CONDITIONS, TABLE 430		
CONDITION		DESCRIPTION
05.	Other Eligibility Considerations.	The following must be considered for AFDC-FC eligibility: A child's eligibility does not depend on the availability of a home to which he can return; The Department must provide services designed to allow the child to return home, where not possible, the family's worker must aggressively pursue other permanent options for the child; A child receiving AFDC-FC who becomes available for adoption, remains eligible to receive AFDC-FC until he is legally adopted. The child must otherwise qualify for AFDC-FC; The child must not receive AFDC-FC and SSI, or AFDC-FC and AFDC, in the same month.

(4-6-05)

01. Child's Age. The child is under the age of eighteen (18), or up to age nineteen (19) if the youth is a full-time student in a secondary school or its equivalent level of vocational or technical training and is expected to complete the educational program before reaching age nineteen (19). ( )

02. Department Custody. The child must remain in the Department's custody through either a current court order or a voluntary placement agreement that has not been in effect more than one hundred and eighty (180) days. ( )

03. Child's Residence. They must continue to live in a *fully* licensed *or approved* foster *family* home, *or childcare* institution, or *on* a court-ordered home visit. ( )

04. Redetermination. A redetermination is used for a child who: ( )

a. Left foster care; ( )

b. Was placed in a Title IV-E ineligible living situation such as: unlicensed placement, a hospital, or a detention center; ( )

c. Exceeded one hundred eighty (180) days in a voluntary placement agreement in which there was no judicial determination of "best interests." The child's Title IV-E eligibility ceases on the 181st day; and ( )

d. Is on a home visit that exceeds the time specified in the court order signed by the Judge without a new judicial determination granting an extension. ( )

05. Annual Redetermination. Annual redetermination is required to assure that the court has determined that the Department has made reasonable efforts to finalize a permanency plan for the child within twelve (12) months of the date the child is considered to have entered foster care and at least once every twelve (12) months thereafter while the child is in foster care. ( )

431. *AFDC-FC AND SSI ELIGIBILITY.* (RESERVED)

When a child is eligible for both AFDC-FC and SSI, the caretaker relative(s) or the family services worker, in consultation with the child's family, must choose the type of payment the child will receive. (5-3-03)

432. TITLE XIX FOSTER CHILD.

A foster child residing in a foster home, children's agency or children's institution approved by the Department is eligible for Title XIX Medicaid if he satisfies all of the following conditions: For Title XIX Medicaid eligibility for a foster child, please refer to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," Section 536. (5-8-09)( )

~~***01. Eligibility Conditions**. A foster child is eligible if:* (3-30-01)~~

~~***a.** He is under age twenty-one (21);* (3-30-01)~~

~~***b.** He is not a recipient of AFDC-FC or SSI;* (3-30-01)~~

~~***c.** A Departmental program other than the Medical Assistance or Welfare Programs has assumed full or partial financial responsibility for him;* (3-30-01)~~

~~***d.** His countable resources do not exceed the AFDC resource limit. In addition to the AFDC resource exclusions, the child may have an additional amount up to five thousand dollars ($5,000) excluded if held in trust for him;* (3-30-01)~~

~~***e.** After applying the applicable AFDC income exclusions and earned income disregards, an additional income disregard of seventy dollars ($70) is deducted; and* (3-30-01)~~

~~***f.** Total income must not exceed two hundred thirteen dollars ($213) monthly.* (3-30-01)~~

~~***02. Ongoing Eligibility**. If a foster child is determined eligible to receive Title XIX Medicaid, the following provisions apply:* (3-30-01)~~

~~***a.** His eligibility must be redetermined at least once every six (6) months.* (3-30-01)~~

~~***b.** His eligibility must cease and other funding sources for medical care must be utilized if the foster home's license is revoked or expires and an application for license renewal is not on file, or if the child returns to his own home even if the Department retains legal custody of such child.* (3-30-01)~~

~~***03. Hospitalized Foster Child**. Where a child who is otherwise eligible for Title XIX Medicaid as a foster child is placed in a hospital prior to being physically placed in foster care, the child is considered to be living in a licensed foster care situation if the regional team appointed to review hospitalization of foster children certified in writing that the plan for the child is to place him in foster care immediately upon discharge from the hospital. The certification must include the estimated date on which the child will enter foster care.* (3-30-01)~~

433. INCOME, BENEFITS AND SAVINGS OF CHILDREN IN FOSTER CARE.
On behalf of the child and with the assistance of ~~*RDU*~~ CWFT staff, family services workers ~~*is*~~ are required to identify and apply for income or benefits from (one (1) or) every available source including Social Security, ~~*veterans' benefits,*~~ tribal benefits, or estates of deceased parents. The address of the payee must be DHW-FACS-~~*RDU*~~CWFT, 450 West State Street, P. O. Box 83720 Boise, ID 83720-0036. ~~(5-8-09)~~( )

434. FORWARDING OF BENEFITS.

01. Home Visit. If the Department is receiving benefits and the child is returned to the home of the parent(s) or legal guardian(s) or relatives for a trial visit, Child Support Services must be notified by ~~*memo from*~~ a family services worker giving the name and address of the person ~~*to whom these benefits are to be forwarded*~~ in order to discontinue accrual of child support owed to the State. ~~(5-8-09)~~( )

0~~1~~2. **Return to ~~*Alternate*~~ Foster Care**. If the child returns to ~~*alternate*~~ foster care, the Department's Child Support Unit must be notified immediately of the correct payee. ~~(5-8-09)~~( )

~~***02. Review After Six Months**. If an alternative care placement continues for a period of six (6) months, a careful review must be initiated to determine if a change of payee must be accomplished.* (3-18-99)~~

(BREAK IN CONTINUITY OF SECTIONS)

437. ACCOUNTING AND REPORTING.
The Department's Division of Family and Community Services, ~~*Resource Development Unit*~~ Child Welfare Funding Team must account for the receipt of funds and develop reports showing how much money has been received and how it has been utilized. ~~*(5-8-09)*~~( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.12 – RULES GOVERNING THE IDAHO CHILD CARE PROGRAM (ICCP)

DOCKET NO. 16-0612-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the 2018 legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 56-202, Idaho Code, and CFR 45 Part 98.42.

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 amended these rules to clarify and align with the Reauthorization of Child Care and Development Block Grant federal regulations. The Department implemented new health and safety requirements for child care providers around safe sleep for infants, streamlining and clarifying the processes for determining eligibility, and updated terms and references needed to meet federal and state requirements.

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 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 317-328**.

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 state general funds or to the federally-funded block grant for these proposed rule changes. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Ericka Rupp at (208) 334-5641.

DATED this 3rd day of November, 2017.

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 PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202, Idaho Code, and CFR 45 Part 98.42.

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 18, 2017.

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 amending these rules to clarify and align with the Re-Authorization of Child Care and Development Block Grant federal regulations. The Department is implementing new health and safety requirements for child care providers around safe sleep for infants, streamlining and clarifying the processes for determining eligibility, and updating terms and references needed to meet federal and state requirements.

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

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

There is no anticipated fiscal impact to state general funds or to the federally-funded block grant for these proposed rule changes. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking as this rule change aligns with federal regulations. The Idaho Child Care Program facilitated seven "open forums" with providers throughout the state. Information was shared with providers about rule additions for safe sleep practices that are needed to complete the federal requirements and received feedback from providers on the new health and safety trainings implemented this year.

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 Ericka Rupp at (208) 334-5641.

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 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0612-1701

010. DEFINITIONS AND ABBREVIATIONS -- A THROUGH L.
The following definitions and abbreviations apply to this chapter: (4-2-08)

01. AABD. Aid to the Aged, Blind, and Disabled. (4-2-08)

02. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, or child care practices and result in an unnecessary cost to the Idaho Child Care Program, in reimbursement that is not necessary, or that fail to meet professional recognized standards for child care, or result in physical harm, pain, or mental anguish to children. (7-1-09)

03. Child. Any person under age eighteen (18) who is under the care of a parent, relative, or ~~*a person eighteen (18) years of age or older who is claimed on tax returns as a dependent*~~ someone acting in loco parentis. ~~*(4-2-08)*~~( )

04. Child Care. Care, control, supervision, or maintenance of a child provided for compensation by an individual, other than a parent, for less than twenty-four (24) hours in a day. (4-2-08)

05. Claim. Any request or demand for payment, or document submitted to initiate payment, for items or services provided under the Idaho Child Care Program. (7-1-09)

06. Department. The Idaho Department of Health and Welfare or its designee. (7-1-09)

07. Earned Income. Income received by a person as wages, tips, or self-employment income before deductions for taxes or any other purposes. (4-2-08)

08. Employment. A job paying wages or salary at federal or state minimum wage, whichever is applicable, including work paid by commission or in-kind compensation. Full or part-time participation in a VISTA or AmeriCorps program is also employment. (4-2-08)

09. Foster Care. The twenty-four (24) hour substitute care of children in the legal custody of the state of Idaho provided in a state licensed foster home by persons who may or may not be related to a child. Foster care is provided in lieu of parental care and is arranged through a private or public agency. (3-2-17)

10. Foster Child. A child in the legal custody of the state of Idaho placed for twenty-four (24) hour substitute care by a private or public agency. (3-2-17)

11. Foster Home. The private home of an individual or family licensed under the state of Idaho and providing twenty-four (24) hour substitute care to six (6) or fewer children. (3-2-17)

12. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person. (7-1-09)

13. Good Cause. The conduct of a reasonably prudent person in the same or similar circumstances, unless otherwise defined in these rules. (7-1-99)

14. In Loco Parentis. Acting "in loco parentis" means a person who acts in place of a parent, assuming care and custody of a child ~~*by a formal or informal agreement with the child's parent*~~ by legal guardianship. ~~*(4-2-08)*~~( )

15. Intentional Program Violation (IPV). An intentional false or misleading action, omission, or

statement made in order to qualify as a provider or recipient in the Idaho Child Care program or to receive program benefits or reimbursement. (7-1-09)

16. Job Training and Education Program. A program designed to provide job training or education. Programs may include high school, junior college, community college, college or university, general equivalency diploma (GED), technical school, and vocational programs. To qualify as a Job Training and Education Program, the program must prepare the trainee for employment. (4-2-08)

17. Infant/Toddler. A child less than forty-eight (48) months of age. (3-2-17)

18. Incapacitated Parent. A parent who is determined by a licensed practitioner of the healing arts to be unfit, incapable, or significantly limited in his ability to provide adequate care for his child or ward. (3-2-17)

19. Knowingly, Known, or With Knowledge. With respect to information or an action about which a person has actual knowledge of the information or action; acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (7-1-09)

20. Legal Guardian. A court-appointed individual who acts as the primary caretaker of a child or minor. ( )

2~~0~~1. **Licensed Practitioner of the Healing Arts**. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. (4-2-08)

011. DEFINITIONS AND ABBREVIATIONS -- M THROUGH Z.
The following definitions and abbreviations apply to this chapter of rules: (4-2-08)

01. Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an organization or entity. (7-1-09)

02. Minor Parent. A parent under the age of eighteen (18). (4-2-08)

03. Non-Recurring Lump Sum Income. Income received by a family in a single payment, not expected to be available to the family again. (7-1-99)

04. Parent. A person responsible for a child because of birth, adoption, ~~*step-parent*~~ marriage, ~~*or*~~ legal guardianship, foster care; or a person acting in loco parentis. ~~*(4-2-08)*~~( )

05. Preventive Services. Services needed to reduce or eliminate the need for protective intervention. Preventive services permit families to participate in activities designed to reduce or eliminate the need for out-of-home placement of a child by the Department. (4-2-08)

06. Prospective Income. Income a family expects to receive within a given time. This can be earned or unearned income. (7-1-99)

07. Provider. An individual, organization, agency, or other entity providing child care. (7-1-99)

08. Relative Provider. Grandparent, great-grandparent, aunt, uncle, or adult sibling by blood or current marriage who provides child care. (4-2-08)

09. SSI. Supplemental Security Income. (4-2-08)

10. Special Needs. Any child with physical, mental, emotional, behavioral disabilities, or developmental delays identified on an Individual Education Plan (IEP) or an Individualized Family Service Plan (IFSP). (4-2-08)

11. State Median Income (SMI). State Median Income Estimates in the Code of Federal Regulations are available on the U.S. Government Publishing Office website at https://www.gpo.gov/fdsys. (3-2-17)

12. TAFI. Temporary Assistance for Families in Idaho. (4-2-08)

13. Unearned Income. Unearned income includes retirement, interest child support, and any income received from a source other than employment or self-employment. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

070. INCOME LIMITS.
To be eligible for child care assistance, a family's countable income must meet the following guidelines using the published Federal Poverty Guidelines (FPG) available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. (3-2-17)

01. Income at Application. At the time of application, a family's income must not exceed one hundred thirty percent (130%) of the Federal Poverty Guidelines (FPG) for a family of the same size. (3-2-17)

02. Income During Eligibility Period. During the eligibility period, when a family's countable income exceeds eighty-five percent (85%) of the State Median Income (SMI) for a family of the same size, the family becomes ineligible for child care assistance. (3-2-17)

03. Income at Time of Redetermination. At the time of redetermination, if a family's income exceeds one hundred thirty percent (130%) of the Federal Poverty Guidelines (FPG) for a family of the same size, ~~*but does not exceed eighty-five percent (85%) of the State Median Income (SMI) for a family of the same size,*~~ the family may be eligible to receive a graduated phase out of child care assistance. ~~*(3-2-17)*~~( )

071. COUNTABLE INCOME.
All gross earned and unearned income is counted in determining eligibility and the child care benefit amount, unless specifically excluded under Section 072 of these rules. (5-1-11)

072. EXCLUDED INCOME.
The following sources of income are not counted as family income. (4-2-08)

01. Earned Income of a Dependent Child. Income earned by a dependent child under age eighteen (18) is not counted, unless the child is a parent who is seeking or receiving child care benefits. (4-2-08)

02. Income Received for Person Not Residing With the Family. Income received on behalf of a person who is not living in the home. (4-2-08)

03. Educational Funds. All educational funds including grants, scholarships, an AmeriCorps Education Award, and federal and state work-study income. (4-2-08)

04. Assistance. Assistance to meet a specific need from other organizations and agencies. (4-2-08)

05. Lump Sum Income. Non-recurring ~~*or*~~ lump sum income is excluded ~~*as income if it is used to pay medical bills resulting from accident or injury, or used to pay funeral or burial costs. When lump sum income, minus exclusions, exceeds current income limits for a family of the same size, the family is not eligible to receive child care benefits. The period of ineligibility is computed by dividing the lump sum payment by the family's monthly income limit. In no case will the period of ineligibility exceed twelve (12) months*~~. ~~*(4-2-08)*~~( )

06. Loans. A loan is money received that is to be repaid. (3-2-17)

07. TAFI and AABD Benefits. (4-4-13)

08. Foster Care Payments. (4-4-13)

09. AmeriCorps/VISTA Volunteers. Living allowances, wages and stipends paid to AmeriCorps or VISTA volunteers under 42 U.C.S. 5044, P.L. 93-113, Title IV, Section 404(g) are excluded as income. (4-2-08)

10. Income Tax Refunds and Earned Income Tax Credits. Income tax refunds and earned income tax credits are excluded as income. (4-2-08)

11. Travel Reimbursements. Reimbursements from employers for work-related travel. (4-2-08)

12. Tribal Income. Income received from a tribe for any purpose other than direct wages. (4-2-08)

13. Foster Parents' Income. Income of licensed foster parents is excluded when determining eligibility for a foster child. Income is counted when determining eligibility for the foster parent's own child(ren). (4-2-08)

14. Adoption Assistance. Adoption assistance payments are excluded from income. (4-2-08)

15. Temporary Census Income. All wages paid by the Census Bureau for temporary employment related to U.S. Census activities are excluded for a time period not to exceed six (6) months during the regularly scheduled ten-year U.S. Census. (4-7-11)

16. Office of Refugee Resettlement Assistance. (4-4-13)

17. Workforce Investment Act (WIA) Benefits or Workforce Innovation and Opportunity Act (WIOA) Benefits. (3-2-17)

(BREAK IN CONTINUITY OF SECTIONS)

077. CONVERTING INCOME TO A MONTHLY AMOUNT.
If a full month's income is expected, but is received on other than a monthly basis, convert the income to a monthly amount using one of the formulas below: (5-1-11)

01. Weekly Amount. Multiply weekly amounts by four point three (4.3). (5-1-11)

02. Bi-Weekly Amount. Multiply bi-weekly amounts by two point one five (2.15). (5-1-11)

03. Semi-Monthly Amount. Multiply semi-monthly amounts by two (2). (5-1-11)

04. ~~*Salary*~~ Monthly Amount. Use the exact monthly income if it is expected for each month of the certification period. ~~*(5-1-11)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

103. COOPERATION IN ESTABLISHMENT OF PATERNITY AND OBTAINING SUPPORT.
~~*If a minor child has a non-custodial parent, the biological*~~ A natural or adoptive parent, or other individual who lives with ~~*the child*~~ and exercises parental control over a minor child who has an absent parent, must cooperate in establishing paternity for the child and obtaining child support. ~~*(3-26-08)*~~( )

01. Providing All Information. "Cooperation" includes providing all information to identify and locate the non-custodial parent~~. *At a minimum, the first and last name of the non-custodial parent and at least two (2) of the following pieces of information must be provided*~~, unless good cause for non-cooperation exists. ~~*(3-26-08)*~~( )

~~*a. Birth date;* (3-26-08)~~

~~*b. Social Security Number;* (3-26-08)~~

~~*c. Current address;* (3-26-08)~~

~~*d. Current phone number;* (3-26-08)~~

~~*e. Current employer;* (3-26-08)~~

~~*f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; and* (3-26-08)~~

~~*g. Name, phone numbers and addresses of the parents of the non-custodial parent.* (3-26-08)~~

02. Established Case for Custodial Parent. After Child Support Services (CCS) has established a case for a custodial parent, all child support payments must be sent directly to CSS. If the custodial parent receives child support directly from the non-custodial parent, the custodial parent must forward the payment to CSS for receipting. (3-26-08)

03. Failure to Cooperate. (3-26-08)

a. Failure to cooperate includes failure to complete the non-custodial or alleged parent information or filiation affidavit as requested, failure to sign the limited power of attorney, or evidence of failure to cooperate provided by Child Support Services (CSS). (3-2-17)

b. When a parent or individual fails to cooperate in establishing paternity and obtaining support, the family is not eligible to participate in the Idaho Child Care Program. (3-26-08)

04. Exemptions From Cooperation Requirement. The parent or individual will not be required to provide information about the non-custodial or alleged parent or otherwise cooperate in establishing paternity or obtaining support if good cause for not cooperating exists. Good cause for failure to cooperate must be provided. (3-26-08)

a. Good cause for failure to cooperate in obtaining support is: (3-26-08)

i. Proof the child was conceived as a result of incest or forcible rape; (3-26-08)

ii. Proof the non-custodial parent may inflict physical or emotional harm to the children, the custodial parent or individual exercising parental control. This must be supported by medical evidence, police reports, or as a last resort, an affidavit from a knowledgeable source; and (3-26-08)

iii. Substantial and credible proof is provided indicating the custodial parent cannot provide the minimum information regarding the non-custodial parent. (3-26-08)

b. A parent or individual claiming good cause for failure to cooperate must submit a notarized statement to the Department identifying the child for whom the exemption is claimed. The statement must list the reasons for the good cause claim. (3-26-08)

c. The cooperation requirement will be waived if good cause exists. No further action will be taken to establish paternity or obtain support. If good cause does not exist the parent will be notified that he is not eligible to receive Idaho Child Care program benefits, until child support cooperation as been obtained. (3-26-08)

104. FAMILY COMPOSITION.
A family is a group of individuals living in a common residence, whose combined income is considered in determining eligibility and the child care benefit amount. No individual may be considered a member of more than

one (1) family in the same month. The following individuals are included in determining the family composition: (4-2-08)

01. Married Parents. Married parents living together in a common residence, includes biological, adoptive, step-parent, guardian, and foster parent. ~~(5-1-11)~~( )

02. Unmarried Parents. Unmarried parents who live in the same home and who have a child in common living with them. (4-2-08)

03. Dependents. Individuals who are ~~claimed as~~ dependents of a parent, guardian, or caretaker relative and living in the home at the primary residence. ~~(3-2-17)~~( )

04. Minor Parent. A minor parent and child are considered a separate family when they apply for child care benefits, even if they live with other relatives. (4-2-08)

05. Individual Acting In Loco Parentis. An individual acting in loco parentis who is eligible to apply for child care benefits, and the child's natural or adoptive parents are not living in the home. (3-2-17)

06. Citizenship or Alien Status Requirement. Family members who are not citizens or living lawfully in the United States will not be counted in the family size. The income of those non-counted family members will be counted when determining the household's income according to Sections 070 through 099 of these rules.

(BREAK IN CONTINUITY OF SECTIONS)

200. QUALIFYING ACTIVITIES FOR CHILD CARE BENEFITS.
To be eligible for child care benefits, each parent included in the household must need child care because they are engaged in one (1) of the qualifying activities listed in Subsections 200.01 through 200.05 of this rule. (5-1-11)

01. Employment. The parent is currently employed. (4-2-08)

02. Self-Employment. The parent is currently self-employed in a business that is a sole proprietorship. A sole proprietorship is a business owned by one (1) person. Restrictions apply for self-employment as follows: (5-8-09)

a. For the first twelve (12) months of self-employment benefits, actual activity hours are used. (3-2-17)

b. At ~~the time of redetermination~~ month thirteen (13), the number of activity hours will be limited. To calculate the activity hours, the net monthly self-employment income is divided by the current federal minimum wage. The qualifying activity hours are the lesser of the calculated activity hours or actual activity hours. ~~(3-2-17)~~( )

03. Training or Education. The parent is attending an accredited education or training program. The following restrictions apply to training or education activities: (4-2-08)

a. On-line classes cannot be counted as a qualifying activity for child care. (4-2-08)

b. Persons who are attending post-baccalaureate classes with no other qualifying activity, do not qualify for child care benefits. (3-2-17)

c. More than forty-eight (48) months of post-secondary education has been used as a qualifying activity. (3-2-17)

04. Preventive Services. The parent is receiving preventive services as defined in Section 011 of these rules. The Department will verify the continued need for preventive services at least every three (3) months. (4-2-08)

05. Personal Responsibility Contract (PRC) or Other Negotiated Agreement. The parent is completing Personal Responsibility Contract (PRC) or other self-sufficiency activities negotiated between the Department and the parent. (4-4-13)

(BREAK IN CONTINUITY OF SECTIONS)

500. ALLOWABLE CHILD CARE COSTS.
Care provided to an eligible child by an eligible child care provider is payable subject to the following conditions: (4-2-08)

01. Payment for Employment, Training, Education, or Preventive Service Hours. Child care must be reasonably related to the hours of the parent's qualifying activities. (5-1-11)

02. One-Time Registration Fees. One-time fees for registering a child in a child care facility are payable above the local market rate, if the fee is charged to all who enroll in the facility. ~~*Fees may*~~ Reimbursement can not exceed two hundred fifty dollars ($250) and must be usual and customary rates charged to all families. Registration fees are separate from local market rates. ~~*(3-2-17)*~~( )

501. NON-ALLOWABLE CHILD CARE COSTS.
Care provided to an eligible child is not payable under the following conditions: (3-2-17)

01. Family Member or Guardian Providing Child Care. A parent, step-parent, or ~~*unmarried parent*~~ guardian will not be paid for providing child care to ~~*his*~~ their own child or ward. ~~*A guardian will not be paid for providing child care to his ward. Absent parents, or anyone living in the absent parent's home are not eligible to receive ICCP payment.*~~ ~~*(3-2-17)*~~( )

02. Provider Living at Same Address as Child. ICCP will not pay for in-home child care if the provider lives at the same address as the child. (3-2-17)

03. School Tuition, Academic Credit, or Tutoring. ICCP payments will not be made for school tuition, academic credit, or tutoring for school age children; this includes: (3-2-17)

a. Any services provided to such students during the regular school day, including kindergarten; (3-2-17)

b. Any services for which such students receive academic credit toward graduation; or (3-2-17)

c. Any instructional services which supplant or duplicate the academic program of any public or private school. (3-2-17)

502. AMOUNT OF PAYMENT.
Child care payments will be based on Subsections 502.01 through 502.04 of this rule. (3-2-17)

01. Payment Rate. Payment will be based on the lower of the provider's usual and customary rates or the Local Market Rate (LMR). (3-2-17)

a. The local market rates for child care are the maximum monthly amounts that ICCP will pay for any given category of child care in a geographic area designated by the Department. The local market rates for child care are established based on a comprehensive survey of child care providers. Using information gathered in the survey, including the age of child, the type of child care, and the designated area where the provider does business, a local market rate is specified for each category of child care. The rate survey is conducted triennially. (3-2-17)

b. Payment rates will be determined by the location of the child care facility. (3-2-17)

c. If the child care facility is not in Idaho, the local market rate will be the rate where the family lives. (4-2-08)

02. Usual and Customary Rates. Rates charged by the child care provider must not exceed the usual and customary rates charged for child care to persons not entitled to receive benefits under ICCP. (7-1-09)

03. In-Home Care. Parents are responsible to pay persons providing care in the child's home the minimum wage, as required by the Fair Labor Standards Act (29 U.S.C. 206a) and other applicable state and federal requirements. ~~*Department payments must not exceed the lower of the hourly federal minimum wage or actual cost of care.*~~ ~~*(4-2-08)*~~( )

04. Payments. Payments will be issued directly to eligible providers. (3-2-17)

(BREAK IN CONTINUITY OF SECTIONS)

600. CHANGE REPORTING REQUIREMENTS.
A family who receives child care benefits must report the following permanent changes by the tenth day of the month following the month in which the change occurred. (4-4-13)

01. Change in ~~*Eligible*~~ Full-time or Part-time Activity Hours. ~~*(4-4-13)*~~( )

02. Change in ~~*Your*~~ Permanent Address. ~~*(5-1-11)*~~( )

03. Change in Household Composition. (4-4-13)

04. Change in Income. ~~*(3-2-17)*~~

~~***a.*** *When the household's total gross income exceeds one hundred thirty percent (130%) of the Federal Poverty Guideline (FPG) for the household size.* *(4-4-13)*~~

~~***b.***~~ When the household's total gross income exceeds the income limit for the program, as described the higher of either one hundred and thirty percent (130%) of the Federal Poverty Guidelines (FPG) or eighty-five percent (85%) of the State Median Income (SMI) for a family of the same size. ~~*(3-2-17)*~~( )

05. Change in Child Care Provider. (5-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

602. REDETERMINATION OF ELIGIBILITY FOR CHILD CARE BENEFITS.

01. Redetermination. The Department must redetermine eligibility for child care benefits at least every twelve (12) months. (3-2-17)

02. Graduated Phase Out. At the time of redetermination, if a household's income exceeds one hundred thirty percent (130%) of the Federal Poverty Guidelines (FPG) for a family of the same size~~*, but does not exceed eighty five percent (85%) of the State Median Income (SMI) for a family of the same size, benefits for*~~ eligible children ~~*will be paid for three (3) months in an amount equal to the payment amount of the 12th month of eligibility, if all other eligibility criteria are met*~~ may receive a graduated phase out benefit. Graduated phase out benefits are limited to twelve (12) months following the completion of a redetermination. ~~*(3-2-17)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

701. RECOUPMENT OF OVERPAYMENTS.

~~***01. Recoupment of Overpayments.***~~ The Department may recoup or recover the amount paid for child care services from a provider or a parent. Interest will accrue on these overpayments at the statutory rate set under Section 28-22-104, Idaho Code, from the date of the final determination of the amount owed for services. Interest will not accrue on overpayments made due to Department error. An overpayment due to family, agency, or provider error, IPV or fraud must be recovered in full. A parent or provider may negotiate a repayment schedule with the Department. ~~(3-2-17)~~( )

~~***02. Parental Repayment Requirement.*** *A parent must repay any overpayment resulting from the parent's failure to report changes within ten (10) days as required in Section 600 of these rules. The parent may negotiate a repayment schedule with the Department. Failure to comply with the negotiated repayment agreement will result in loss of the family's eligibility to receive child care benefits. Ineligibility will continue until the parent repays the overpayment or a new repayment agreement is negotiated with the Department.* (5-1-11)~~

702. INTENTIONAL PROGRAM VIOLATIONS (IPV).
An IPV is an intentionally false or misleading action or statement as identified below in Subsections 702.01 through 702.08 of this rule. An IPV is established when a family member or the child care provider admits the IPV in writing and waives the right to an administrative hearing, or when determined by an administrative hearing, a court decision, or through deferred adjudication. Deferred adjudication exists when the court defers a determination of guilt because the accused family member or child care provider meets the terms of a court order or an agreement with the prosecutor. (4-2-08)

01. False Statement. An individual makes a false statement to the Department, either orally or in writing, in order to participate in the Idaho Child Care Program. (4-2-08)

02. Misleading Statement. An individual makes a misleading statement to the Department, either orally or in writing, to participate in the Idaho Child Care Program. (4-2-08)

03. Misrepresentation of Fact. An individual misrepresents one (1) or more facts to the Department, either orally or in writing, to participate in the Idaho Child Care Program. (4-2-08)

04. Concealing Fact. An individual conceals or withholds one (1) or more facts to participate in the Idaho Child Care Program. (4-2-08)

05. Non-Compliance With Rules and Regulations. An individual fails repeatedly or substantially to comply with this chapter of rules. (4-2-08)

06. Violation of Provider Agreement. An individual knowingly violates any term of his provider agreement. (4-2-08)

~~***07. Failure to Repay.*** *An individual has failed to repay, or was a managing employee or had an ownership or control interest in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation, or provider agreement.* (4-2-08)~~

0~~8~~7. **Failure to Meet Qualifications**. A provider fails to meet the qualifications specifically required by this chapter of rules or by any applicable licensing board. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

802. HEALTH AND SAFETY REQUIREMENTS.
All providers must comply with the health and safety requirements listed in Subsections 802.01 through 802.13 of this rule. All providers must agree to an annual, unannounced health and safety inspection, with the exception of in-home child care described in Section 401 of these rules. Compliance with these standards does not exempt a provider

from complying with stricter health and safety standards under state law, tribal law, local ordinance, or other applicable law. (3-2-17)

01. Age of Provider. All child care providers providing services must be eighteen (18) years old or older. Persons sixteen (16) or seventeen (17) years old may provide child care if they have direct, on-site supervision from a licensed child care provider who is at least eighteen (18) years old. (4-2-08)

02. Sanitary Food Preparation. Food for use in child care facilities must be prepared and served in a sanitary manner. Utensils and food preparation surfaces must be cleaned and sanitized before using to prevent contamination. (4-2-08)

03. Food Storage. All food served in child care facilities must be stored to protect it from potential contamination. (4-2-08)

04. Hazardous Substances. Medicines, cleaning supplies, and other hazardous substances must be handled safely and stored out of the reach of children. Biocontaminants must be disposed of appropriately. (3-2-17)

05. Emergency Communication. A telephone or some type of emergency communication system is required. (4-2-08)

06. Smoke Detectors, Fire Extinguishers, and Exits. A properly installed and operational smoke detector must be on the premises where child care occurs. Adequate fire extinguishers and fire exits must be available on the premises. (4-2-08)

07. Hand Washing. Each provider must wash his hands with soap and water at regular intervals, including before feeding, after diapering or assisting children with toileting, after nose wiping, and after administering first aid. (4-2-08)

08. CPR/First Aid. Providers must insure that at all times children are present at least one (1) adult on the premises has current certification in pediatric rescue breathing (CPR) and pediatric first aid treatment from a certified instructor. (3-2-17)

09. Health of Provider. Each provider must certify that he does not have a communicable disease or any physical or psychological condition that might pose a threat to the safety of a child in his care. (4-2-08)

10. Child Abuse. Providers must report suspected child abuse to the appropriate authority. (4-2-08)

11. Transportation. Providers who transport children as part of their child care operations must operate safely and legally, using child safety restraints and seat belts as required by state and local statutes. (3-2-17)

12. Disaster and Emergency Planning. Providers must have documented policies and procedures planning for emergencies resulting from a natural disaster, or man-caused event that include: (3-2-17)

a. Evacuation, relocation, shelter-in-place, and lock-down procedures, and procedures for communication and reunification with families, continuity of operations, and accommodation of infants and toddlers, children with disabilities, and children with chronic medical conditions. (3-2-17)

b. Procedures for staff and volunteer emergency preparedness training and practice drills. (3-2-17)

c. Guidelines for the continuation of child care services in the period following the emergency or disaster. (3-2-17)

13. Environmental Safety. Building and physical premises must be safe, including identification of and protection from hazards that can cause bodily injury including electrical hazards, bodies of water, and vehicular traffic. (3-2-17)

14. Safe Sleep. Providers must place newborn infants to twelve (12) months in a safe sleep

environment. Safe sleep practices include, alone, on their backs, and in a Consumer Product Safety Commission (CPSC) certified crib. ( )

803. CHILD CARE PROVIDER TRAINING REQUIREMENTS.
Each child care provider must receive and ensure that each staff member who provides child care receives and completes twelve (12) hours of ongoing training every twelve (12) months after the staff member's date of hire. (3-2-17)

01. Training Contents. Training must be related to continuing education in child development, teaching and curriculum, health and safety, and business practices. ~~*The following*~~ Pediatric rescue breathing (CPR) and pediatric first aid treatment training will not count towards the required twelve (12) hours of annual training~~:~~. ~~*(3-2-17)*~~( )

~~***a.*** *Pediatric rescue breathing (CPR) and pediatric first aid treatment training; and* *(3-2-17)*~~

~~***b.*** *Trainings related to participation with the Child and Adult Care Food Program (CACFP).* *(3-2-17)*~~

02. Documented Training. It is the responsibility of the child care provider to ensure that each staff member who provides child care has completed twelve (12) hours of training each year. The training must be documented in the staff member's record. (3-2-17)

03. Staff Training Records. Each child care provider is responsible for maintaining documentation of staff's training and must produce this documentation when the provider agreement is renewed annually. (3-2-17)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.15 – BEHAVIORAL HEALTH PROGRAMS

DOCKET NO. 16-0715-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 Title 39, Chapter 31, Idaho Code, 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:

These rules clarify that an individual who is seeking to provide services as a peer, but whose Department Criminal History Check was denied, may apply for a Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs." 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 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 188-191**.

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 for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 16th day of November, 2017.

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 31, Idaho Code, 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 20, 2017.

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 updates these rules to clarify that an individual who has lived experience and is seeking to provide services as a peer, but whose Department Criminal History Check was denied, may apply for a Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs."

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

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

There is no anticipated fiscal impact to the State General Fund or any other funds for this rule change. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking as this rule change simply adds clarification language that the Behavioral Health waiver process is used for peers wanting to provide peer services.

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 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 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0715-1701

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. 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 participants, must comply with the provisions of IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-16)

02. Availability to Work. An individual, listed in Subsection 009.01 of this rule, is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted 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. (7-1-16)

a. An individual is allowed to work or have access to participants only under supervision until the criminal history and background check is completed. (7-1-16)

b. An individual, who does not receive a criminal history and background check clearance or a waiver granted under the provisions in these rules, may not provide direct care or services, or serve in a position that requires regular contact with participants. (7-1-16)

03. Waiver of Criminal History and Background Check Denial. A~~n~~ certified or uncertified individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an unconditional denial or a denial after an exemption review by the Department's Criminal History Unit, may apply for a Behavioral Health waiver to provide direct care or services, or serve in a position that requires regular contact with participants. 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. ~~(7-1-16)~~( )

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: (7-1-16)

a. Forcible sexual penetration by use of a foreign object, as defined in Section 18-6608, Idaho Code; (7-1-16)

b. Incest, as defined in Section 18-6602, Idaho Code; (7-1-16)

c. Lewd conduct with a minor, as defined in Section 18-1508, Idaho Code; (7-1-16)

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; (7-1-16)

e. Possession of sexually exploitative material, as defined in Section 18-1507A, Idaho Code; (7-1-16)

f. Rape, as defined in Section 18-6101, Idaho Code; (7-1-16)

g. Sale or barter of a child, as defined in Section 18-1511, Idaho Code; (7-1-16)

h. Sexual abuse or exploitation of a child, as defined in Sections 18-1506 and 18-1507, Idaho Code; (7-1-16)

i. Enticing of children, as defined in Sections 18-1509 and 18-1509A, Idaho Code; (7-1-16)

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; (7-1-16)

k. Any felony punishable by death or life imprisonment; or (7-1-16)

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. (7-1-16)

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 for waivers of CHC denials described in Subsections 009.03 and 009.04 of this rule. (7-1-16)

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 thirty (30) calendar days from the date of the issuance of a denial from the Department's Criminal History Unit. The thirty (30) day period for submitting a request for a waiver may be extended by the Department for good cause. (7-1-16)

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. (7-1-16)

08. Factors Considered During Administrative Review. During the administrative review, the following factors may be considered: (7-1-16)

a. The severity or nature of the crimes or other findings; (7-1-16)

b. The period of time since the incidents occurred; (7-1-16)

c. The number and pattern of incidents being reviewed; (7-1-16)

d. Circumstances surrounding the incidents that would help determine the risk of repetition; (7-1-16)

e. The relationship between the incidents and the position sought; (7-1-16)

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. (7-1-16)

g. A pardon that was granted by the Governor or the President; (7-1-16)

h. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and (7-1-16)

i. Any other factor deemed relevant to the review. (7-1-16)

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. (7-1-16)

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 these rules is not a criminal history and background check clearance. A waiver is only applicable to the specified individual on the waiver and for behavioral health services and programs governed under these rules. The waiver does not apply to other Department programs

that require a clearance for a Department criminal history and background check. (7-1-16)

11. Revocation of Waiver. At any time, the Department may revoke a waiver at its discretion for circumstances that it identifies as a risk to participants' health and safety. (7-1-16)

12. Waiver Decisions Are Not Subject to Review or Appeal. The decision or actions of the Department concerning a waiver are not subject to review or appeal, administratively, or otherwise. (7-1-16)

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. (7-1-16)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.17 – SUBSTANCE USE DISORDERS SERVICES

DOCKET NO. 16-0717-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 Title 39, Chapter 31, Idaho Code, and Section 56-1003, Idaho Code.

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

The rules allow Recovery Support Services (RSS) to access the Behavioral Health waiver process established in rule when a Department Criminal History Check clearance is denied for an individual wanting to provide peer 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 September 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 192-193**.

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 for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 16th day of November, 2017.

Tamara Prisock
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Phone: (208) 334-5500
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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 31, Idaho Code, and Section 56-1003, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 20, 2017.

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 Division of Behavioral Health promulgated rules effective July 1, 2016, that removed the process for the Department's Criminal History and Background Checks from this chapter and added them into IDAPA 16.07.15, "Behavioral Health Programs." The unintended consequence of this action has been that providers of Recovery Support Services (RSS) only are unable to access the Behavioral Health waiver process established in rule when a Department Criminal History Check clearance is denied for an individual wanting to provide peer services.

This rule change reinstates the Behavioral Health waiver process for "Recovery Support Services only" providers that are providing peer services. The Legal Authority section of these rules is being updated for statutes necessary for this requirement.

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

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

There is no anticipated fiscal impact to the State General Fund or any other funds for this rule change. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking as this rule change adds reference language for the Behavioral Health waiver process for peers providing Recovery Support Services when a criminal history clearance is denied. Providers and affected parties have requested the Department reinstate this process that was previously available.

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 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 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0717-1701

000. LEGAL AUTHORITY.
The Idaho Legislature has delegated to the Department and the Board of Health and Welfare, the responsibility to establish and enforce rules for a comprehensive and coordinated program for the treatment of substance use disorders. This authority is found in the Alcoholism and Intoxication Treatment Act, Title 39, Chapter 3, ~~*and*~~. The Director of the Department is authorized to administer rules to promote health, safety, and services dealing with substance use disorders under Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code.
~~*(7-1-16)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

007. -- 00~~9~~8. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. All providers of substance use disorder recovery support services may be subject to the Department enhanced clearance as defined in IDAPA 16.05.06, "Criminal History and Background Checks," Section 010. ( )

a. Recovery Support Services providers that are subject to the Department enhanced clearance must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," Section 126, for applicants receiving a Department enhanced clearance. ( )

b. For the purpose of processing background checks for these individuals, a recovery support services program will be considered a Behavioral Health Program as that class of individuals is described in IDAPA 16.05.06, "Criminal History and Background Checks," Section 126. ( )

02. Availability to Work or Provide Service. An individual listed in Subsection 009.01 of this rule is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted 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. ( )

a. An individual is allowed to work or have access to participants only under supervision until the criminal history and background check is completed. ( )

b. An individual, who does not receive a criminal history and background check clearance or have a Behavioral Health waiver granted under the provisions in Subsection 009.03 of this rule, must not provide direct care or services, or serve in a position that requires regular contact with participants. ( )

03. Waiver of Criminal History and Background Check Denial. A certified or uncertified individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an unconditional denial or a denial after an exemption review by the Department's Criminal History Unit, may apply for a Behavioral Health waiver as described in IDAPA 16.07.15 "Behavioral Health Programs," Section 009. ( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.30 – BEHAVIORAL HEALTH COMMUNITY CRISIS CENTERS

DOCKET NO. 16-0730-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 Title 39, Chapter 31, Idaho Code, and Sections 39-3133, 39-3140, 56-1003, 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:

These rules clarify that the Behavioral Health waiver process is for individuals seeking to provide services as a peer, but whose Department Criminal History Check was denied. The waiver process in this chapter is being removed to reference the Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs." 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 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 194-197**.

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 for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 3rd day of November, 2017.

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 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 31, Idaho Code, and Sections 39-3133, 39-3140, 56-1003, 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 20, 2017.

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 that the Behavioral Health waiver process is for individuals who have lived experience and are seeking to provide services as a peer, but whose Department Criminal History Check was denied. The waiver process in this chapter is being removed as being redundant and these rules refer to the Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs."

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

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

There is no anticipated fiscal impact to the State General Fund or any other funds for this rule change. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking as this rule change simply adds reference language for the Behavioral Health waiver process for peers in another chapter of rules.

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 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 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0730-1701

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 a behavioral health community crisis center. (7-1-14)

03. Waiver of Criminal History and Background Check Denial. A~~n~~ certified or uncertified individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an ~~conditional or~~ unconditional denial ~~for a~~ or a denial after an exemption review by the Department's ~~c~~Criminal ~~h~~History ~~and background check~~ Unit, may apply for a Behavioral Health waiver ~~to provide direct care or services, or serve in a position that requires regular contact with clients accessing adult mental health services through the Department. 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~~ as described in IDAPA 16.07.15 "Behavioral Health Programs," Section 009. ~~(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.** Forcible 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)~~

~~**c.** 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 choose 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 are 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)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.33 – ADULT MENTAL HEALTH SERVICES

DOCKET NO. 16-0733-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 39-3133, and 56-1003, 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:

This rulemaking clarifies that the Behavioral Health waiver process is for individuals seeking to provide services as a peer, but whose Department Criminal History Check was denied. The waiver process in this chapter is being removed to reference the Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs." 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 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9, pages 198-201**.

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:

There is no anticipated fiscal impact to the State General Fund or any other funds for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 3rd day of November, 2017.

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 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 39-3133, and 56-1003, 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 20, 2017.

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 that the Behavioral Health waiver process is for individuals who have lived experience and are seeking to provide services as a peer, but whose Department Criminal History Check was denied. The waiver process in this chapter is being removed as being redundant and these rules refer to the Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs."

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

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

There is no anticipated fiscal impact to the State General Fund or any other funds for this rule change. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking as this rule change simply adds reference language for the Behavioral Health waiver process for peers in another chapter of rules.

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 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 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0733-1701

000. LEGAL AUTHORITY.
The Idaho Legislature has delegated to the Department of Health and Welfare, as the state mental health authority, the responsibility to ensure that mental health services are available throughout the state of Idaho to individuals who need such care and who meet certain eligibility criteria under the Regional Mental Health Services Act, Title 39, Chapter 31, Idaho Code. Under Section 39-3133, Idaho Code, the Department is authorized to promulgate rules to carry out the purposes and intent of the Regional Mental Health Services Act. Under Sections 56-1003(3)(c), 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code, the Director is authorized to adopt rules to supervise and administer a mental health program. ~~(5-8-09)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

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 accessing adult mental health services through the Department. (7-1-14)

03. Waiver of Criminal History and Background Check Denial. A~~n~~ certified or uncertified individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an ~~conditional or~~ unconditional denial or a denial after an exemption review ~~for a~~ by the Department's ~~c~~Criminal ~~h~~History ~~and background check~~ Unit, may apply for a Behavioral Health waiver ~~to provide direct care or services, or serve in a position that requires regular contact with clients accessing adult mental health services through the Department. 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~~ as described in IDAPA 16.07.15 "Behavioral Health Programs," Section 009. ~~(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.** Forcible 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)~~

~~**c.** 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)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.37 – CHILDREN'S MENTAL HEALTH SERVICES

DOCKET NO. 16-0737-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: The effective date of the temporary rule is January 1, 2018. The pending rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 and is also adopting this rule as a temporary rule. The action is authorized pursuant to Sections 16-2404, 16-2406, 16-2423, 16-2433, 56-202(b), 56-203B, 56-204A, 56-1003, 56-1004, 56-1004A, 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.

These pending and temporary rules remove tables that provide reimbursement amounts for foster care, and add references to IDAPA 16.06.01, "Child and Family Services," that provide payments to alternate care providers. Also, changes were made for class members covered by a court-ordered settlement agreement for grievances and expedited hearings.

In accordance with Section 67-5226, Idaho Code, the full text of the temporary rule is being published in this Bulletin following this notice. There are no changes to the pending rule and it is being adopted as originally proposed. The original text of the proposed rule was published in the (October 4, 2017, Idaho Administrative Bulletin, **Vol. 17-10, pages 329-331**.

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:

Changes to these rules confer a benefit to the individuals who are covered under the Jeff D Settlement agreement that needs to be in place January 1, 2018.

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

The fiscal impact for these rule changes are meant to be cost-neutral. Items being removed or amended in this chapter are covered under other rules and have no fiscal impact to state general funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule or temporary rule, contact Treena Clark at (208) 334-6611.

DATED this 3rd day of November, 2017.

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 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 16-2404, 16-2406, 16-2423, 16-2433, 56-202(b), 56-203B, 56-204A, 56-1003, 56-1004, 56-1004A, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 18, 2017.

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 amendments remove tables that provide reimbursement amounts for foster care, and add references to IDAPA 16.06.01, "Child and Family Services," that provide payments to alternate care providers. Also, changes are being made for class members covered by a court-ordered settlement agreement for grievances and expedited hearings.

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

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

The fiscal impact for these rule changes are meant to be cost-neutral. Items being removed or amended in this chapter are covered under other rules and have no fiscal impact to state general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiate these changes due to the simple nature of the change for duplicated rules and to comply with a court-ordered settlement agreement.

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 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 October 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0737-1701

003. ADMINISTRATIVE APPEALS.

01. Appeal from a Denial Based on Eligibility Criteria. Administrative appeals from a denial of children's mental health services based on the eligibility criteria under Section 107 of these rules are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-17)

02. Grievances and Expedited Hearings. Grievances and expedited hearings related to non-Medicaid Youth Empowerment Services (YES) will be provided as described in IDAPA 16.05.03 "Rules Governing Contested Case Proceeding and Declaratory Ruling," Sections 750 and 751. ( )

02~~3~~. Appeal of Decision Based on Clinical Judgment. All decisions involving clinical judgment, which may include the category of services, the particular provider of services, or the duration of services, are reserved to the Department, and are not subject to appeal, administratively or otherwise, in accordance with Maresh v. State, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

283. PAYMENT TO FAMILY ALTERNATE CARE PROVIDERS.
Monthly payments for care provided by family alternate care providers~~:~~ are paid according to IDAPA 16.06.01, "Child and Family Services."

~~Family Alternate Care Payments - Table 283~~			
~~Ages~~	~~0-5~~	~~6-12~~	~~13-18~~
~~Monthly Room and Board~~	~~$329~~	~~$366~~	~~$487~~

~~(7-1-17)~~( )

01. Gifts. ~~An a~~Additional ~~thirty dollars ($30)~~ payments for Christmas gifts and ~~twenty dollars ($20) for~~ birthday gifts will be paid in the appropriate months. ~~(5-8-09)~~( )

02. Clothing. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. (5-8-09)

03. School Fees. School fees due upon enrollment will be paid directly to the school or to the foster parents, based upon the Department's determination of the child's needs. (5-8-09)

284. ADDITIONAL PAYMENTS TO FAMILY ALTERNATE CARE PROVIDERS.
For those children who, as determined by the Department, require additional care above room, board, shelter, daily supervision, school supplies, and personal incidentals, the Department may pay the family alternate care provider an additional amount to that paid ~~under Section 283 of these rules.~~ according to IDAPA 16.06.01, "Child and Family Services." The family alternate care rate is based upon a continuous ongoing assessment of the child's circumstances which necessitate special rates as well as the care provider's ability, activities, and involvement in addressing those special needs. ~~Additional payment will be made as follows:~~

~~Additional Family Alternate Care Payments - Table 284~~		
~~Lowest Level of Need~~	~~Moderate Level of Need~~	~~Highest Level of Need~~
~~$90 per month~~	~~$150 per month~~	~~$240 per month~~

~~(7-1-17)~~( )

01. Lowest Level of Need. ~~Ninety dollars ($90) per month for a~~ A child requiring a mild degree of care for documented conditions ~~including~~ receives the lowest level of additional payments for the following:
~~(5-8-09)~~( )

a. Chronic medical problems; (5-8-09)

b. Frequent, time-consuming transportation needs; (5-8-09)

c. Behaviors requiring extra supervision and control; and (5-8-09)

d. Need for preparation for independent living. (5-8-09)

02. Moderate Level of Need. ~~One hundred fifty dollars ($150) per month for a~~ A child requiring a moderate degree of care for documented conditions ~~including~~ receives the moderate level of additional payments for the following:
~~(5-8-09)~~( )

a. Ongoing major medical problems; (5-8-09)

b. Behaviors that require immediate action or control; and (5-8-09)

c. Alcohol or other substance use disorder. (5-8-09)

03. Highest Level of Need. ~~Two hundred forty dollars ($240) per month for a~~ A child requiring an extraordinary degree of care for documented conditions ~~including~~ receives the highest level of additional payments for the following:
~~(5-8-09)~~( )

a. Serious emotional or behavioral disorder that requires continuous supervision; (5-8-09)

b. Severe developmental disability; and (5-8-09)

c. Severe physical disability such as quadriplegia. (5-8-09)

04. Reportable Income. Additional payments for more than ten (10) qualified children received during any calendar year must be reported as income to the Internal Revenue Service. (5-8-09)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.50 – MINIMUM STANDARDS FOR NONHOSPITAL, MEDICALLY MONITORED DETOXIFICATION/MENTAL HEALTH DIVERSION UNITS

DOCKET NO. 16-0750-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 Title 39, Chapter 3, Idaho Code, "Alcoholism and Intoxication Treatment Act," 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:

These rules allow an individual who is seeking to provide services as a peer, but whose Department Criminal History Check was denied, to apply for a Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs." 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 6, 2017, Idaho Administrative Bulletin, **Vol. 17-9 pages 202-203**.

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 for this rule change. This rulemaking is intended to be cost-neutral.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Treena Clark at (208) 334-6611.

DATED this 16th day of November, 2017.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
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Phone: (208) 334-5500
Fax: (208) 334-6558
E-mail: **dhwrules@dhw.idaho.gov**

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Title 39, Chapter 3, Idaho Code, 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 20, 2017.

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 to update these rules to allow an individual who has lived experience and is seeking to provide services as a peer, but whose Department Criminal History Check was denied, to apply for a Behavioral Health Waiver described in IDAPA 16.07.15, "Behavioral Health Programs."

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

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

There is no anticipated fiscal impact to the State General Fund or any other funds for this rule change. This rulemaking is intended to be cost-neutral.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking as this rule change simply adds reference language for the Behavioral Health waiver process for peers in another chapter of rules.

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 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 27, 2017.

DATED this 4th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0750-1701

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. Each detox/mental health diversion unit must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." Criminal history and background checks must be completed on the owner, employees, applicants, transfers, reinstated former employees, student interns, contractors, and volunteers who provide care or services, or have access to clients in a detox/mental health diversion unit. The applicant is responsible for the cost of the criminal history and background check except where otherwise provided by Department rules. (3-29-10)

02. Availability to Work. Any individual hired or contracted with, who has direct client access, must self-disclose all arrests and convictions before having access to clients. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any client. An individual is allowed to work only under supervision until the criminal history and background check is completed. (3-29-10)

03. Waiver of Criminal History and Background Check Denial. A certified or uncertified individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an unconditional denial, or a denial after an exemption review by the Department's Criminal History Unit, may apply for a Behavioral Health waiver described in IDAPA 16.07.15, "Behavioral Health Programs," Section 009. ( )

IDAPA 19 – IDAHO STATE BOARD OF DENTISTRY

19.01.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 54-912, Idaho Code.

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

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 6, 2017 Idaho Administrative Bulletin, **Vol. 17-9, pages 225-231**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Miller, Executive Director, at (208) 334-2369.

DATED this 10th day of October, 2017.

Susan Miller
Executive Director
Idaho Board of Dentistry
350 N. 9th St., Ste. M100
P. O. Box 83720
Boise, ID 83720-0021
Phone: (208) 334-2369
Fax: (208) 334-3247

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, 54-912 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 20, 2017.

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 19.01.01.004 is being amended to delete the American Dental Association's sedation-related documents as incorporated by reference. The rules regarding moderate sedation (19.01.01.060) are being amended by the addition of qualifying course requirements.

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 is budget neutral and has no fiscal impact to the state general fund or the Board of Dentistry's dedicated fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the July 5, 2017 Idaho Administrative Bulletin, **Volume 17-7, page 69**. Comments were received and considered before initiating this proposed rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Miller, Executive Director, (208) 334-2369.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2017.

DATED this 10th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 19-0101-1701

004. INCORPORATION BY REFERENCE (RULE 4).
Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the following documents: (7-1-93)

01. Professional Standards. (3-29-12)

a. American Association of Oral and Maxillofacial Surgeons, Office Anesthesia Evaluation Manual, 8th Edition, 2012. (3-20-14)

~~***b.*** *American Dental Association, Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, October 2007.* (4-7-11)~~

~~***c.*** *American Dental Association, Guidelines for the Use of Sedation and General Anesthesia by Dentists, October 2007.* (4-7-11)~~

~~***d.*** *American Dental Association Policy Statement: The Use of Sedation and General Anesthesia by Dentists, October 2007.* (4-7-11)~~

~~***e***~~**b.** Centers for Disease Control and Prevention, DHHS, Guidelines for Infection Control in Dental Health-Care Settings, 2003. (4-6-05)

~~***f***~~**c.** American Dental Association, Principles of Ethics, Code of Professional Conduct and Advisory Opinions (ADA Code), January 2009. (4-7-11)

~~***g***~~**d.** American Dental Hygienists' Association, Code of Ethics for Dental Hygienists (ADHA Code), June 2009. (4-7-11)

~~***h***~~**e.** American Dental Hygienists' Association, Standards for Clinical Dental Hygiene Practice, March 10, 2008. (4-7-11)

02. Availability. These documents are available for public review at the Idaho State Board of Dentistry, 350 North 9th Street, Suite M-100, Boise, Idaho 83720. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

060. MODERATE SEDATION (RULE 60).
Dentists licensed in the state of Idaho cannot administer moderate sedation in the practice of dentistry unless they have obtained the proper moderate sedation permit from the Idaho State Board of Dentistry. A moderate sedation permit may be either enteral or parenteral. A moderate enteral sedation permit authorizes dentists to administer moderate sedation by either enteral or combination inhalation-enteral routes of administration. A moderate parenteral sedation permit authorizes a dentist to administer moderate sedation by any route of administration. A dentist shall not administer moderate sedation to children under sixteen (16) years of age and one hundred (100) pounds unless they have qualified for and been issued a moderate parenteral sedation permit. (3-29-12)

01. Requirements for a Moderate Enteral Sedation Permit. To qualify for a moderate ~~*enteral*~~ sedation permit, a dentist applying for a permit shall provide proof that the dentist has completed training in the administration of moderate sedation to a level consistent with that prescribed ~~*in the American Dental Association's "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," as incorporated in Section 004 in these rules*~~ by the Board within the five (5) year period immediately prior to the date of application for a

moderate sedation permit. The five (5) year requirement regarding the required training for a moderate ~~enteral~~ sedation permit shall not be applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the application date. ~~To obtain a moderate enteral sedation permit, a dentist must provide verification of~~ Qualifying training courses must be sponsored by or affiliated with a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or be approved by the Board of Dentistry. The training program shall include the following: ~~(4-11-15)~~( )

~~a. Completion of an American Dental Association accredited or Board of Dentistry approved post-doctoral training program within five (5) years of the date of application for a moderate enteral sedation permit that included documented training of a minimum of twenty-four (24) hours of instruction plus management of at least ten (10) adult case experiences by the enteral and/or enteral nitrous oxide/oxygen route. These ten (10) cases must include at least three live clinical dental experiences managed by participants in groups no larger than five (5). The remaining cases may include simulations and/or video presentations, but must include one experience in returning a patient from deep to moderate sedation; and~~ ~~(4-7-11)~~

~~b. Current certification in Advanced Cardiac Life Support.~~ ~~(4-11-15)~~

~~02. Requirements for a Moderate Parenteral Sedation Permit. To qualify for a moderate parenteral sedation permit, a dentist applying for a permit shall provide proof that the dentist has completed training in the administration of moderate parenteral sedation as prescribed in the American Dental Association's "Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students," as incorporated in Section 004 of these rules within the five (5) year period immediately prior to the date of application for a moderate parenteral sedation permit. The five (5) year requirement shall not be applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the date of application. The training program shall:~~ ~~(4-7-11)~~

~~a. Be sponsored by or affiliated with a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or a teaching hospital or facility approved by the Board of Dentistry; and~~ ~~(4-5-00)~~

~~b. Consist of a minimum of sixty (60) hours of instruction, plus management of at least twenty (20) patients by the intravenous route; and~~ ~~(4-7-11)~~

~~c. Include the issuance of a certificate of successful completion that indicates the type, number of hours, and length of training received.~~ ~~(3-18-99)~~

~~d. In addition, the dentist must maintain current certification in Advanced Cardiac Life Support or Pediatric Advanced Life Support, whichever is appropriate for the patient being sedated.~~ ~~(3-29-17)~~

a. Course objectives: ( )

i. List and discuss the advantages and disadvantages of moderate sedation; ( )

ii. Discuss prevention, recognition and management of complications associated with moderate sedation; ( )

iii. Administer moderate sedation to patients in a clinical setting in a safe and effective manner; ( )

iv. Discuss the abuse potential, occupational hazards and other untoward effects of the agents utilized to achieve moderate sedation; ( )

v. Describe and demonstrate the technique of intravenous access, intramuscular injection and other parenteral techniques; ( )

vi. Discuss the pharmacology of the drug(s) selected for administration; ( )

vii. Discuss the precautions, indications, contraindications and adverse reactions associated with the

drug(s) selected; ( )

vii. Administer the selected drug(s) to dental patients in a clinical setting in a safe and effective manner; ( )

ix. List the complications associated with techniques of moderate sedation; ( )

x. Describe a protocol for management of emergencies in the dental office and list and discuss the emergency drugs and equipment required for the prevention and management of emergency situations; ( )

xi. Discuss principles of advanced cardiac life support or an appropriate dental sedation/anesthesia emergency course equivalent; ( )

xii. Demonstrate the ability to manage emergency situations; and ( )

xiii. Demonstrate the ability to diagnose and treat emergencies related to the next deeper level of anesthesia than intended. ( )

c. Course Content: ( )

i. Historical, philosophical and psychological aspects of anxiety and pain control; ( )

ii. Patient evaluation and selection through review of medical history taking, physical diagnosis and psychological considerations; ( )

iii. Use of patient history and examination for ASA classification, risk assessment and pre-procedure fasting instructions; ( )

iv. Definitions and descriptions of physiological and psychological aspects of anxiety and pain; ( )

v. Description of the sedation anesthesia continuum, with special emphasis on the distinction between the conscious and the unconscious state; ( )

vi. Review of pediatric and adult respiratory and circulatory physiology and related anatomy; ( )

vii. Pharmacology of local anesthetics and agents used in moderate sedation, including drug interactions and contraindications; ( )

viii. Indications and contraindications for use of moderate sedation; ( )

ix. Review of dental procedures possible under moderate sedation; ( )

x. Patient monitoring using observation and monitoring equipment, with particular attention to vital signs and reflexes related to consciousness; ( )

xi. Maintaining proper records with accurate chart entries recording medical history, physical examination, informed consent, time-oriented anesthesia record, including the names of all drugs administered including local anesthetics, doses, and monitored physiological parameters; ( )

xii. Prevention, recognition and management of complications and emergencies; ( )

xiii. Description and use of moderate sedation monitors and equipment; ( )

xiv. Discussion of abuse potential; ( )

xv. Intravenous access: anatomy, equipment and technique; ( )

xvi. Prevention, recognition and management of complications of venipuncture and other parenteral techniques; ( )

xvii. Description and rationale for the technique to be employed; and ( )

xviii. Prevention, recognition and management of systemic complications of moderate sedation, with particular attention to airway maintenance and support of the respiratory and cardiovascular systems. ( )

d. Hours of instruction: ( )

i. For a moderate enteral sedation permit, the applicant must provide proof of training with a minimum of twenty-four (24) hours of instruction plus management of at least ten (10) adult case experiences by the enteral and/or enteral-nitrous oxide/oxygen route. These ten (10) cases must include at least three live clinical dental experiences managed by participants in groups no larger than five (5). The remaining cases may include simulations and/or video presentations, but must include one experience in returning a patient from deep to moderate sedation. ( )

ii. For a moderate parenteral sedation permit, the applicant must provide proof of training with a minimum of sixty (60) hours of instruction, plus management of at least twenty (20) patients by the intravenous route. ( )

03. General Requirements for Moderate Enteral and Moderate Parenteral Sedation Permits. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue. Evaluators appointed by the Idaho State Board of Dentistry will periodically assess the adequacy of the facility and competence of the anesthesia team. ~~*The Board adopts the standards incorporated by reference in Section 004.01.c. and Section 004.01.d. of these rules as set forth by the American Dental Association.*~~ ~~*(4-11-15)*~~( )

a. Facility, Equipment and Drug Requirements. The following facilities, equipment and drugs shall be available for immediate use during the sedation and recovery phase: (4-11-15)

i. An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two (2) individuals to freely move about the patient; (4-11-15)

ii. An operating table or chair that permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support; (4-11-15)

iii. A lighting system that permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power failure; (4-11-15)

iv. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure; (4-11-15)

v. An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system; (4-11-15)

vi. A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room; (4-11-15)

vii. A sphygmomanometer, pulse oximeter, oral and nasopharyngeal airways, supraglottic airway devices, and automated external defibrillator (AED); and (4-11-15)

viii. Emergency drugs including, but not limited to, pharmacologic antagonists appropriate to the drugs used, bronchodilators, and antihistamines. (4-11-15)

ix. Additional emergency equipment and drugs required for moderate parenteral sedation permits include precordial/pretracheal stethoscope or end-tidal carbon dioxide monitor, intravenous fluid administration equipment, vasopressors, and anticonvulsants. (3-29-17)

b. Personnel. For moderate sedation, the minimum number of personnel shall be two (2) including: (4-7-11)

i. The operator; and (10-1-87)

ii. An assistant currently certified in Basic Life Support for Healthcare Providers. (4-7-11)

iii. Auxiliary personnel must have documented training in basic life support for healthcare providers, shall have specific assignments, and shall have current knowledge of the emergency cart inventory. The dentist and all office personnel must participate in documented periodic reviews of office emergency protocol, including simulated exercises, to assure proper equipment function and staff interaction. (4-11-15)

c. Pre-sedation Requirements. Before inducing moderate sedation, a dentist shall: (4-11-15)

i. Evaluate the patient's medical history and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation; (4-11-15)

ii. Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian; (4-11-15)

iii. Obtain written informed consent from the patient or patient's guardian for the sedation; and (4-11-15)

iv. Maintain an anesthesia record, and enter the individual patient's sedation into a case/drug log. (4-11-15)

d. Patient Monitoring. Patients shall be monitored as follows: (4-11-15)

i. Patients must be continuously monitored using pulse oximetry. The patient's blood pressure, heart rate, and respiration shall be recorded every five (5) minutes during the sedation and then continued every fifteen (15) minutes until the patient meets the requirements for discharge. These recordings shall be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons shall be documented in the patient's record. A patient under moderate sedation shall be continuously monitored; (3-29-17)

ii. During the recovery phase, the patient must be monitored by an individual trained to monitor patients recovering from moderate sedation; (4-11-15)

iii. A dentist shall not release a patient who has undergone moderate sedation except to the care of a responsible third party; (4-11-15)

iv. The dentist shall assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met: vital signs are stable, patient is alert and oriented, and the patient can ambulate with minimal assistance; and (4-11-15)

v. A discharge entry shall be made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged. (4-11-15)

e. Sedation of Other Patients. The permit holder shall not initiate sedation on another patient until the previous patient is in a stable monitored condition and in the recovery phase following discontinuation of their sedation. (4-11-15)

f. Permit Renewal. Before the expiration date of a permit, the Board will, as a courtesy, mail notice for renewal of permit to the last mailing address on file in the Board's records. The licensee must return the completed renewal application along with the current renewal fees prior to the expiration of said permit. Failure to submit a renewal application and permit fee shall result in expiration of the permit and termination of the licensee's right to administer moderate sedation. Failure to submit a complete renewal application and permit fee within thirty (30) days of expiration of the permit shall result in cancellation of the permit. A licensee whose permit is canceled due to failure to renew within the prescribed time is subject to the provisions of Paragraph 060.03.g. of these rules. Renewal of the permit will be required every five (5) years. Proof of a minimum of twenty-five (25) credit hours continuing education in moderate sedation which may include training in medical/office emergencies will be required to renew a permit. A fee shall be assessed to cover administrative costs. In addition to the continuing education hours, a dentist must: (3-29-17)

i. For a moderate enteral sedation permit, maintain current certification in basic life support for healthcare providers or advanced cardiac life support; (4-11-15)

ii. For a moderate parenteral sedation permit, maintain current certification in advanced cardiac life support. (3-20-14)

g. Reinstatement. A dentist may make application for the reinstatement of a canceled or surrendered permit issued by the Board under this rule within five (5) years of the date of the permit's cancellation or surrender. Applicants for reinstatement of a permit shall satisfy the facility and personnel requirements of this rule and shall be required to verify that they have obtained an average of five (5) credit hours of continuing education in moderate sedation for each year subsequent to the date upon which the permit was canceled or surrendered. A fee for reinstatement shall be assessed to cover administrative costs. (3-29-17)

IDAPA 19 – IDAHO STATE BOARD OF DENTISTRY

19.01.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-1702

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 54-912, Idaho Code.

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

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 6, 2017 Idaho Administrative Bulletin, **Vol. 17-9, pages 232-237**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Miller, Executive Director, at (208) 334-2369.

DATED this 10th day of October, 2017.

Susan Miller
Executive Director
Idaho Board of Dentistry
350 N. 9th St., Ste. M100
P. O. Box 83720
Boise, ID 83720-0021
Phone: (208) 334-2369
Fax: (208) 334-3247

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 54-912, 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 20, 2017.

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 examination rules will be amended to distinguish between written and clinical examination results and to clarify the clinical examination requirements. The dental assistant rule regarding authorization to place a rubber dam will be revised to reflect current nomenclature. The unprofessional conduct rule regarding prescription drugs will be revised for clarification.

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 is budget neutral and has no fiscal impact to the state general fund or the Board of Dentistry's dedicated fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the July 5, 2017 Idaho Administrative Bulletin, **Volume 17-7, page 70**. Comments were received and considered before initiating this proposed rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Miller, Executive Director, (208) 334-2369.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2017.

DATED this 10th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 19-0101-1702

010. EXAMINATIONS (RULE 10).
Examinations may be completed solely by the Board or, at its discretion, the Board may participate in and accept an examining agent. Clinical ~~E~~examination results will be valid for Idaho licensure by examination for a period of five (5) years from the date of successful completion of the examination. ~~(3-29-17)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

014. EXAMINATION FOR GENERAL DENTAL LICENSES (RULE 14).
Pursuant to Section 54-918, Idaho Code, the Board shall conduct both written and clinical examinations of such duration and character and upon such subjects in dentistry as the Board shall determine to thoroughly test the fitness and ability of the applicant to practice dentistry in the state of Idaho. The Board may accept as meeting this requirement successful completion of an examination administered by the Board or its agent, and completion of supplementary examinations as the Board deems necessary to determine the competency of the applicant for licensure. Any exam conducted by the Board may include: (7-1-93)

01. Written Examination. Evidence of passing the National Board examination may be required of all candidates applying for a license to practice dentistry. Any other written examination will be specified by the Board. (7-1-93)

02. Clinical Examination. All applicants for license to practice general dentistry shall be required to pass a Board-approved clinical examination~~, which includes a periodontal examination~~. ~~(3-29-17)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

035. DENTAL ASSISTANTS - PRACTICE (RULE 35).

01. Direct Supervision. A dental assistant may perform specified activities under direct supervision as follows: (4-6-05)

a. Recording the oral cavity (existing restorations, missing and decayed teeth); (4-6-05)

b. Placement of topical anesthetic agents (prior to administration of a local anesthetic by a dentist or dental hygienist); (4-6-05)

c. Removal of excess bonding material from temporary and permanent restorations and orthodontic appliances (using hand instruments or contra-angle handpieces with disks or polishing wheels only); (4-6-05)

d. Expose and process radiographs; (4-6-05)

e. Make impressions for preparation of diagnostic models, bleach trays, fabrication of night guards, temporary appliances, temporary crowns or bridges; (3-20-14)

f. Record diagnostic bite registration; (4-6-05)

g. Record bite registration for fabrication of restorations; (4-6-05)

h. Provide patient education and instruction in oral hygiene and preventive services; (4-6-05)

i. Placement of cotton pellets and temporary restorative materials into endodontic access openings; (4-6-05)

j. Placement and removal of arch wire; (4-6-05)

k. Placement and removal of orthodontic separators; (4-6-05)

l. Placement and removal of ligature ties; (4-6-05)

m. Cutting arch wires; (4-6-05)

n. Removal of loose orthodontic brackets and bands to provide palliative treatment; (4-6-05)

o. Adjust arch wires; (4-6-05)

p. Etching of teeth prior to placement of restorative materials; (4-6-05)

q. Etching of enamel prior to placement of orthodontic brackets or appliances by a Dentist; (4-6-05)

r. Placement and removal of ~~*rubber*~~ dental dam; ~~*(4-6-05)*~~( )

s. Placement and removal of matrices; (4-6-05)

t. Placement and removal of periodontal pack; (4-6-05)

u. Removal of sutures; (4-6-05)

v. Application of cavity liners and bases; (4-6-05)

w. Placement and removal of gingival retraction cord; and (3-20-14)

x. Application of topical fluoride agents. (3-20-14)

02. Prohibited Duties. Subject to other applicable provisions of these rules and of the Act, dental assistants are hereby prohibited from performing any of the activities specified below: (7-1-93)

a. Definitive diagnosis and treatment planning. (4-6-05)

b. The intraoral placement or carving of permanent restorative materials. (3-20-14)

c. Any irreversible procedure using lasers. (3-20-14)

d. The administration of any general or local injectable anesthetic. (3-20-14)

e. Any oral prophylaxis (removal of stains and plaque biofilm and if present, supragingival and/or subgingival calculus). (3-20-14)

f. Use of an air polisher. (3-20-14)

g. Any intra-oral procedure using a high-speed handpiece, except to the extent authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity. (4-6-05)

h. The following expanded functions, unless authorized by a Certificate of Registration or certificate or diploma of course completion issued by an approved teaching entity and performed under direct supervision: (4-6-05)

i. Fabrication and placement of temporary crowns; (4-6-05)

ii. Perform the mechanical polishing of restorations; (7-1-93)

iii. Initiating, regulating and monitoring the administration of nitrous oxide/oxygen to a patient; (4-7-11)

iv. Application of pit and fissure sealants; (7-1-93)

v. Coronal polishing (removal of plaque biofilm and stains from the teeth using an abrasive agent with a rubber cup or brush). (3-20-14)

vi. Use of a high-speed handpiece only for the removal of orthodontic cement or resin. (3-20-14)

03. Expanded Functions Qualifications. A dental assistant may be considered Board qualified in expanded functions, authorizing the assistant to perform any or all of the expanded functions described in Subsection 035.02.h. upon satisfactory completion of the following requirements: (3-29-17)

a. Completion of Board-approved training in each of the expanded functions with verification of completion of the training to be provided to the Board upon request by means of a Certificate of Registration or other certificate evidencing completion of approved training. The required training shall include adequate training in the fundamentals of dental assisting, which may be evidenced by: (4-6-05)

i. Current certification by the Dental Assisting National Board; or (7-1-93)

ii. Successful completion of Board-approved curriculum in the fundamentals of dental assisting; or (3-29-12)

iii. Successfully challenging the fundamentals course. (7-1-93)

b. Successful completion of a Board-approved competency examination in each of the expanded functions. There are no challenges for expanded functions. (3-18-99)

04. Curriculum Approval. Any school, college, institution, university or other teaching entity may apply to the Board to obtain approval of its course curriculum. Before approving such curriculum, the Board may require satisfactory evidence of the content of the instruction, hours of instruction, content of examinations or faculty credentials. (3-29-17)

05. Other Credentials. Assistants, who have completed courses or study programs in expanded functions that have not been previously approved by the Board, may submit evidence of the extent and nature of the training completed, and, if in the opinion of the Board the same is at least equivalent to other Board-approved curriculum, and demonstrates the applicant's fitness and ability to perform the expanded functions, the Board may consider the assistant qualified to perform any expanded function(s). (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

040. UNPROFESSIONAL CONDUCT (RULE 40).
A dentist or dental hygienist shall not engage in unprofessional conduct in the course of his practice. Unprofessional conduct by a person licensed under the provisions of Title 54, Chapter 9, Idaho Code, is defined as, but not limited to, one (1) of the following: (3-20-14)

01. Fraud. Obtaining fees by fraud or misrepresentation, or over-treatment either directly or through an insurance carrier. (7-1-93)

02. Unlicensed Practice. Employing directly or indirectly any suspended or unlicensed dentist or dental hygienist to practice dentistry or dental hygiene as defined in Title 54, Chapter 9, Idaho Code. (7-1-93)

03. Unlawful Practice. Aiding or abetting licensed persons to practice dental hygiene or dentistry

unlawfully. (7-1-93)

04. Dividing Fees. A dentist shall not divide a fee for dental services with another party, who is not a partner or associate with him in the practice of dentistry, unless: (7-1-93)

a. The patient consents to employment of the other party after a full disclosure that a division of fees will be made; (7-1-93)

b. The division is made in proportion to the services performed and responsibility assumed by each dentist or party. (7-1-93)

05. Prescription Drugs. Prescribing or administering prescription drugs not reasonably necessary for, or within the scope of, providing dental services for a patient. ~~*In prescribing or administering prescription drugs, a dentist shall exercise reasonable and ordinary care and diligence and exert his best judgment in the treatment of his patient as dentists in good standing in the state of Idaho, in the same general line of practice, ordinarily exercised in like cases.*~~ A dentist may not prescribe ~~*prescription drugs for*~~ or administer ~~*controlled substances*~~ prescription drugs to himself. A dentist shall not use controlled substances as an inducement to secure or maintain dental patronage or aid in the maintenance of any person's drug addiction by selling, giving or prescribing prescription drugs.
~~*(3-29-17)*~~( )

06. Harassment. The use of threats or harassment to delay or obstruct any person in providing evidence in any possible or actual disciplinary action, or other legal action; or the discharge of an employee primarily based on the employee's attempt to comply with the provisions of Title 54, Chapter 9, Idaho Code, or the Board's Rules, or to aid in such compliance. (7-1-93)

07. Discipline in Other States. Conduct himself in such manner as results in a suspension, revocation or other disciplinary proceedings with respect to his license in another state. (3-18-99)

08. Altering Records. Alter a patient's record with intent to deceive. (7-1-93)

09. Office Conditions. Unsanitary or unsafe office conditions, as determined by the customary practice and standards of the dental profession in the state of Idaho and current recommendations of the American Dental Association and the Centers for Disease Control as referred to in Section 004. (7-1-93)

10. Abandonment of Patients. Abandonment of patients by licensees before the completion of a phase of treatment, as such phase of treatment is contemplated by the customary practice and standards of the dental profession in the state of Idaho, without first advising the patient of such abandonment and of further treatment that is necessary. (7-1-93)

11. Use of Intoxicants. Practicing dentistry or dental hygiene while under the influence of an intoxicant or controlled substance where the same impairs the dentist's or hygienist's ability to practice dentistry or hygiene with reasonable and ordinary care. (7-1-93)

12. Mental or Physical Illness. Continued practice of dentistry or dental hygiene in the case of inability of the licensee to practice with reasonable and ordinary care by reason of one (1) or more of the following: (7-1-93)

a. Mental illness; (7-1-93)

b. Physical illness, including but not limited to, deterioration through the aging process, or loss of motor skill. (7-1-93)

13. Consent. Revealing personally identifiable facts, data or information obtained in a professional capacity without prior consent of the patient, except as authorized or required by law. (3-18-99)

14. Scope of Practice. Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities that the licensee knows or has reason to know that he or she is

not competent to perform. (3-18-99)

15. Delegating Duties. Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows, or with the exercise of reasonable care and control should know, that such a person is not qualified by training or by licensure to perform them. (3-18-99)

16. Unauthorized Treatment. Performing professional services that have not been authorized by the patient or his legal representative. (3-18-99)

17. Supervision. Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of a licensed professional. (7-1-93)

18. Legal Compliance. Failure to comply with any provisions of federal, state or local laws, statutes, rules, and regulations governing or affecting the practice of dentistry or dental hygiene. (3-29-12)

19. Exploiting Patients. Exercising undue influence on a patient in such manner as to exploit a patient for the financial or personal gain of a practitioner or of a third party. (7-1-93)

20. Misrepresentation. Willful misrepresentation of the benefits or effectiveness of dental services. (7-1-93)

21. Disclosure. Failure to advise patients or their representatives in understandable terms of the treatment to be rendered, alternatives, and disclosure of reasonably anticipated fees relative to the treatment proposed. (3-18-99)

22. Sexual Misconduct. Making suggestive, sexual or improper advances toward a patient or committing any lewd or lascivious act upon or with a patient. (7-1-93)

23. Patient Management. Use of unreasonable and/or damaging force to manage patients, including but not limited to hitting, slapping or physical restraints. (7-1-93)

24. Compliance With Dentist Professional Standards. Failure by a dentist to comply with professional standards applicable to the practice of dentistry, as incorporated by reference in this chapter. (3-29-12)

25. Compliance With Dental Hygienist Professional Standards. Failure by a dental hygienist to comply with professional standards applicable to the practice of dental hygiene, as incorporated by reference in this chapter. (3-29-12)

26. Failure to Provide Records to a Patient or Patient's Legal Guardian. Refusal or failure to provide a patient or patient's legal guardian legible copies of dental records. Failure to provide a patient or patient's legal guardian with records under Subsection 040.26 within five (5) business days shall be considered unprofessional conduct. A patient or patient's legal guardian may not be denied a copy of his records for any reason, regardless of whether the person has paid for the dental services rendered. A person may be charged for the actual cost of providing the records but in no circumstances may a person be charged an additional processing or handling fee or any charge in addition to the actual cost. (3-20-14)

27. Failure to Cooperate With Authorities. Failure to cooperate with authorities in the investigation of any alleged misconduct or interfering with a Board investigation by willful misrepresentation of facts, willful failure to provide information upon request of the Board, or the use of threats or harassment against any patient or witness to prevent them from providing evidence. (3-20-14)

28. Advertising. Advertise in a way that is false, deceptive, misleading or not readily subject to verification. (3-29-17)

IDAPA 19 – IDAHO STATE BOARD OF DENTISTRY

19.01.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 19-0101-1703

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 54-912, Idaho Code.

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

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 6, 2017 Idaho Administrative Bulletin, **Vol. 17-9, pages 238-241**.

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: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Susan Miller, Executive Director, at (208) 334-2369.

DATED this 10th day of October, 2017.

Susan Miller
Executive Director
Idaho Board of Dentistry
350 N. 9th St., Ste. M100
P. O. Box 83720
Boise, ID 83720-0021
Phone: (208) 334-2369
Fax: (208) 334-3247

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 54-912, 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 20, 2017.

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 section (19.01.01.066) will be added to further define parameters for teledental services authorized under the Idaho Telehealth Access Act.

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 is budget neutral and has no fiscal impact to the state general fund or the Board of Dentistry's dedicated fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the July 5, 2017 Idaho Administrative Bulletin, **Volume 17-7, page 71**. Comments were received and considered before initiating this proposed rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Miller, Executive Director, (208) 334-2369.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2017.

DATED this 10th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 19-0101-1703

028. VOLUNTEER DENTAL HYGIENE SERVICES (RULE 28).
A person holding an unrestricted active status dental hygienist's license issued by the Board may provide dental hygiene services in an extended access oral health care ~~*program*~~ setting without being issued an extended access dental hygiene license endorsement under the following circumstances: ~~*(3-30-07)*~~( )

01. Extended Access Oral Health Care ~~*Program*~~ Setting. The dental hygiene services must be performed in an extended access oral health care ~~*program*~~ setting under the supervision of a dentist ~~*who is employed, retained by, or is a volunteer for the program*~~ who has issued written orders to the dental hygienist; ~~*(3-20-14)*~~( )

02. Dental Hygiene Services Performed. The dental hygiene services performed shall be limited to oral health screening and patient assessment, preventive and oral health education, preparation and review of health history, non-surgical periodontal treatment, oral prophylaxis, the application of caries preventive agents including fluoride, the application of pit and fissure sealants with recommendation that the patient will be examined by a dentist; (3-20-14)

03. Volunteers. The dental hygienist must perform the dental hygiene services on a volunteer basis and shall not accept any form of remuneration for providing the services; and (3-30-07)

04. Volunteer Time Limit. The dental hygienist may not provide dental hygiene services under this provision for more than five (5) days within any calendar month. (3-30-07)

029. DENTAL HYGIENISTS - LICENSE ENDORSEMENTS (RULE 29).
Subject to the provisions of the Dental Practice Act, Chapter 9, Title 54, Idaho Code, and these rules, the Board may grant license endorsements to qualified dental hygienists as follows: (4-6-05)

01. Extended Access Dental Hygiene Endorsement. Upon application, the Board may grant an extended access dental hygiene endorsement to a person holding an unrestricted active status dental hygienist's license issued by the Board who provides satisfactory proof that all of the following requirements are met: (3-20-14)

a. The person has been licensed as a dental hygienist during the two (2) year period immediately prior to the date of application for an extended access dental hygiene endorsement; (4-6-05)

b. For a minimum of one thousand (1000) total hours within the previous two (2) years, the person has either been employed as a dental hygienist in supervised clinical practice or has been engaged as a clinical practice educator in an approved dental hygiene school; (4-6-05)

c. The person has not been disciplined by the Board or another licensing authority upon grounds that bear a demonstrable relationship to the ability of the dental hygienist to safely and competently practice under general supervision in an extended access oral health care ~~*program*~~ setting; and ~~*(3-20-14)*~~( )

d. Any person holding an unrestricted active status dental hygienist's license issued by the Board who is employed as a dental hygienist in an extended access oral health care ~~*program*~~ setting in this state shall be granted an extended access dental hygiene endorsement without being required to satisfy the experience requirements specified in this rule. ~~*(3-30-07)*~~( )

02. Extended Access Dental Hygiene Restorative Endorsement. Notwithstanding any other provision of these rules, a qualified dental hygienist holding an extended access dental hygiene restorative endorsement may perform specified restorative functions under the direct supervision of a dentist in an extended access oral health care ~~*program*~~ setting. Permissible restorative functions under this endorsement shall be limited to the placement of a restoration into a tooth prepared by a dentist and the carving, contouring and adjustment of the

contacts and occlusion of the restoration. Upon application, the Board may grant an extended access dental hygiene restorative endorsement to a person holding an unrestricted active status dental hygienist's license issued by the Board who provides satisfactory proof that the following requirements are met: ~~(3-30-07)~~( )

a. The person has successfully completed the Western Regional Examining Board's restorative examination or an equivalent restorative examination approved by the Board; or (3-30-07)

b. The person holds an equivalent restorative permit in another state as of the date of endorsement application which required successful completion of the Western Regional Examining Board's restorative examination or an equivalent restorative examination approved by the Board for its issuance; and (3-30-07)

c. The person has not been disciplined by the Board or another licensing authority upon grounds that bear a demonstrable relationship to the ability of the dental hygienist to safely and competently practice under in an extended access oral health care ~~program~~ setting. ~~(3-30-07)~~( )

03. Renewal. Upon payment of the appropriate license fee and completion of required continuing education credits specified for a dental hygiene license endorsement, a person meeting all other requirements for renewal of a license to practice dental hygiene shall also be entitled to renewal of a dental hygiene license endorsement for the effective period of the license. An endorsement shall immediately expire and be cancelled at such time as a person no longer holds an unrestricted active status dental hygienist's license issued by the Board or upon a person's failure to complete the required continuing education credits. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

066. TELEHEALTH SERVICES (RULE 66).
Definitions applicable to these rules are those definitions set forth in the Idaho Telehealth Access Act and in Section 54-5703, Idaho Code. ( )

01. Licensure and Location. Any dentist or dental hygienist who provides any telehealth services to patients located in Idaho must hold an active Idaho license issued by the Idaho State Board of Dentistry for their applicable practice. Dentists who provide any telehealth services must physically practice within seventy-fine (75) miles of the patient's location. ( )

02. Additional Requirements. 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 Dentistry who is providing telehealth services shall: ( )

a. Verify the location and identity of the patient; ( )

b. Disclose to the patient the provider's identity, their current location and telephone number and Idaho license number; ( )

c. 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 ( )

03. 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 in order to make a diagnosis, the provider shall not provide diagnosis or treatment through telehealth services unless or until such information is obtained. ( )

04. 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: ( )

a. Verification. Identification of the patient, the provider and the provider's credentials; ( )

b. 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; ( )

c. 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; ( )

d. Potential Information Loss. Disclosure that information may be lost due to technical failures. ( )

IDAPA 22 – BOARD OF MEDICINE

22.01.13 – RULES FOR THE LICENSURE OF DIETITIANS

DOCKET NO. 22-0113-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized Pursuant to Section 54-3505(2), 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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 335-341**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Anne K. Lawler, Executive Director, at (208) 327-7000.

DATED this 2nd day of November, 2017.

Anne K. Lawler, JD, RN
Executive Director
Idaho State Board of Medicine
1755 Westgate Drive, Suite 140
Boise, ID 83704
Phone: (208) 327-7000
Fax: (208) 327-7005
E-mail: **anne.lawler@bom.idaho.gov**

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized Pursuant to Section 54-3505(2), Idaho Code.

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

PUBLIC HEARING
Wednesday, November 1, 2017 - 1:00 to 2:00 pm (MDT)

Idaho State Board of Medicine
1755 Westgate Drive, Suite 140
Boise, ID 83704

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

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

These rules update the Board's rules regarding Dietetic licensure and practice, making the Dietetic rules consistent with the Dietetic Practice Act that was updated during the 2017 Legislative Session. These rules update Dietitians' scope of practice, definitions, and organizational titles, and add the option for licensure by endorsement.

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

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

This rule change 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 conducted with interested parties, including the state association, and such negotiations shall continue through the comment period and hearing.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact 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 November 1, 2017.

DATED this 25th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0113-1701

010. DEFINITIONS.

01. Academy of Nutrition and Dietetics. The national organization that credentials dietetics professionals and accredits undergraduate and graduate programs that prepare dietetics professionals. ( )

02. Accreditation Council for Education in Nutrition and Dietetics. Accreditation Council for Education in Nutrition and Dietetics or "ACEND" means the accrediting organization of the Academy of Nutrition and Dietetics that is recognized by the United States Department of Education as the accrediting agency for education programs that prepare dietetic professionals. ( )

0~~1~~3. Board. The Idaho State Board of Medicine. (4-2-03)

0~~2~~4. Dietitian. A person who meets all of the requirements of and is licensed under the provisions of Title 54, Chapter 35, Idaho Code, to engage in the practice of dietetics as set forth in Section 54-350~~5(3)~~2A, Idaho Code. Dietitian and dietician are interchangeable terms. ~~(4-2-03)~~( )

0~~3~~5. Dietetic Practice. As set forth in Title 54, Chapter 35, Section 3502A of the Idaho Code, ~~D~~dietetic practice, the practice of dietetics or practicing dietetics ~~*means the integration and application of principles derived from the sciences of nutrition, biochemistry, food physiology, management, and behavioral and social sciences to achieve and maintain human health through the provision of medical nutrition services and the development of therapeutic nutrition care plans to assist in the maintenance of health and the prevention and treatment of disorders of body function, systems or organs*~~ focuses on food and nutrition and related services developed and provided by dietitians to protect the public, enhance the health and well-being of patients/clients, and to deliver quality products, programs and services, and medical nutrition therapy. Clinical nutrition and dietetics practice is the utilization of skills, knowledge and applied judgment of the dietitian whose practice involves nutrition care, medical nutrition therapy, and related services provided to individuals and groups of all ages to address health promotion and prevention, delay or management of diseases and conditions. Dietetic practice is across varied settings, including health care, business and industry, communities and public health systems, schools, colleges, the military, government, research, food service management, teaching, consulting, media, writing, public speaking and informatics, and private practice. ~~(4-2-03)~~( )

06. Commission on Dietetic Registration (CDR). The credentialing organization of the Academy of Nutrition and Dietetics that awards and administers credentials to individuals at entry, specialist and advanced levels who have met CDR's specified criteria to practice in the dietetics profession, including successful completion of its national accredited certification examination and recertification by continuing professional education and/or examination. ( )

0~~4~~7. Licensure Board. The Dietetic Licensure Board. (4-2-03)

0~~5~~8. Medical Nutrition ~~*Services*~~ Therapy. Medical nutrition ~~*services refers to the nutritional assessment, the design and implementation of therapeutic nutrition care plans, and nutrition therapy counseling provided by a licensed dietitian*~~ therapy or "MNT" means an evidence-based application of the nutrition care process. The provision of MNT to a patient/client may include one (1) or more of the following: nutrition assessment or reassessment, nutrition diagnosis, and nutrition intervention for the prevention, delay or management of diseases or conditions. ~~(4-2-03)~~( )

0~~6~~9. Monitor of Provisionally Licensed Graduate Dietitian. An Idaho licensed dietitian who shall be responsible for the activities of the provisionally licensed graduate dietitian being supervised and shall review and countersign all patient documentation performed by the provisionally licensed graduate dietitian being supervised. (4-2-03)

~~07. Nutritional Assessment. The evaluation of nutritional needs of individuals and groups based upon appropriate biochemical, anthropometric, physical, and dietary data which is necessary to determine nutrient needs and to recommend appropriate enteral or parenteral nutritional intake. (4-2-03)~~

~~08. Nutrition Therapy Counseling. The advising or assisting individuals or groups on appropriate nutrient intake by integrating information from the nutritional assessment and therapeutic nutrition care plan with information on food and other sources of nutrients and meal preparation consistent with health needs, disease state, psychological status, cultural background, and available resources. (4-2-03)~~

10. ~~Therapeutic~~ Nutrition Care ~~Plan~~ Process. A ~~plan of care developed by a licensed dietitian that includes~~ systematic approach to providing high-quality nutrition care that consists of four (4) distinct, interrelated steps: ~~(4-2-03)~~( )

~~a. The design and implementation of nutrition goals and objectives for individuals and groups for the maintenance of health and prevention of disease; (4-2-03)~~

~~b. The design and implementation of therapeutic nutrition regimens, including enteral and parenteral nutrition for the treatment of disorders of body functions, systems, or organs; (4-2-03)~~

~~c. Establishing priorities, goals, and objectives that meet nutritional needs and are consistent with available resources and constraints; (4-2-03)~~

~~d. Developing, implementing, and managing nutrition care systems; and (4-2-03)~~

~~e. Evaluating, making changes in, and maintaining appropriate standards of quality in food and nutrition care services. (4-2-03)~~

a. Nutrition assessment, which means a systematic method for obtaining, verifying and interpreting data needed to evaluate nutritional needs and to identify nutrition-related problems, their causes and their significance; ( )

b. Nutrition diagnosis, which means the identification of a specific nutrition problem that a dietitian is responsible for treating independently; ( )

c. Nutrition intervention, which means a purposefully planned action intended to positively change a nutrition-related behavior, environmental condition or aspect of health status for the patient/client and family or caregivers, target group or the community at large; and ( )

d. Nutrition monitoring and evaluation: ( )

i. Nutrition monitoring means the preplanned review and measurement of selected nutrition care indicators of the patient/client's status relevant to the defined needs, nutrition diagnosis, nutrition intervention and outcomes; and ( )

ii. Nutrition evaluation means the systematic comparison of current findings with the previous status, nutrition intervention goals, effectiveness of overall nutrition care or comparison to a reference standard. ( )

~~09~~11. **Provisional License**. The Board may issue a provisional license to a graduate dietitian who meets the requirements set forth by Sections 54-3506(1) and 54-3506(2), Idaho Code. A provisional license shall authorize the practice of dietetics under the supervision of a monitor who is an Idaho licensed dietitian. (4-2-03)

011. -- 019. (RESERVED)

020. GENERAL QUALIFICATIONS FOR LICENSURE.

01. Applicant. An applicant must be of good moral character and shall meet the requirements set forth

in Section 54-3506, Idaho Code. The Board may refuse licensure if it finds the applicant has engaged in conduct prohibited by Section 54-3510, Idaho Code, provided, the Board shall take into consideration the rehabilitation of the applicant and other mitigating circumstances. (12-28-94)

02. Examination. Each applicant shall either pass an examination required by the Board or shall be entitled to apply for ~~a waiver~~ Licensure by Endorsement pursuant to Section 54-3508, Idaho Code. ~~(4-2-03)~~( )

a. The written examination shall be the examination conducted by the Commission on Dietetic Registration and the passing score shall be the passing score established by the Commission. (12-28-94)

b. An applicant who fails to pass the examination must submit a new application. (12-28-94)

c. An applicant who has failed to pass the examination on two (2) separate occasions will be denied eligibility to reapply; however, this application may be considered on an individual basis if the applicant submits proof of additional training. ~~(12-28-94)~~( )

d. An applicant for Licensure by Endorsement will meet the requirements as set forth in Section 54-3508, Idaho Code. ( )

03. Application Expiration. An application upon which the applicant takes no further action will be held for no longer than one (1) year. (12-28-94)

021. APPLICATION FOR LICENSURE.

01. Application. Each applicant for licensure shall submit a completed written application to the board on forms prescribed by the board, together with the application fee. The application shall be verified and under oath and shall require the following information: (12-28-94)

a. A certificate of successful completion of a program approved by the Academy of Nutrition and Dietetics or its successor and a certificate of successful completion of a dietetic internship or preprofessional program approved or accredited by the Academy of Nutrition and Dietetics or its successor organization; ~~(3-20-14)~~( )

b. The disclosure of any criminal conviction or charges against the applicant other than minor traffic offenses; (12-28-94)

c. The disclosure of any disciplinary action against the applicant by any state professional regulatory agency or professional organization; (12-28-94)

d. The disclosure of the denial of registration or licensure by any state or district regulatory body; (12-28-94)

e. No~~t less~~ fewer than two (2) certificates of recommendation from persons having personal knowledge of the applicant's character; ~~(12-28-94)~~( )

f. Two (2) unmounted photographs of the applicant, no larger than three inches by four inches (3" x 4") (head and shoulders), taken not more than one (1) year prior to the date of the application; (12-28-94)

g. A copy of any registration by the Commission on Dietetic Registration, if applicable; (12-28-94)

h. A copy of examination results or the application to write the qualifying exam and the date the examination is scheduled; (4-2-03)

i. Such other information as deemed necessary for the Board to identify and evaluate the applicant's credentials; and (4-2-03)

j. A Provisional License Dietitian/Monitor Affidavit, if applicable. (4-2-03)

02. Personal Interview. The Board may, at its discretion, require the applicant to appear for a personal interview. This interview shall be limited to a review of the applicant's qualifications and professional credentials. *(12-28-94)*( )

022. LICENSE EXPIRATION AND RENEWAL.

01. Provisional Licensure Expiration. Provisional licenses shall become full active licenses to practice as a dietitian upon the date of receipt of a copy of registration by the Commission on Dietetic Registration. All provisional licenses shall expire on June 30 following issuance. (4-2-03)

02. Renewal. Each full license shall be renewed annually or biennially before July 1 of the expiration year by submitting a completed request for renewal accompanied by payment of the renewal fee and a copy of current registration as a registered dietitian, as determined by the Commission on Dietetic Registration of the American Dietetic Association, or *current credentialing as a credentialed dietitian by any other association which is also recognized by the National Commission for Health Certifying Agencies to the Board* its successor organization. Full licenses not renewed by the expiration date shall be canceled. *(4-2-03)*( )

023. PROVISIONAL LICENSURE.

01. Provisional License. The Board may issue a provisional license to a person who has successfully completed the academic requirements of an education program in dietetics approved by the licensure board and has successfully completed a dietetic internship or preprofessional practice program, coordinated program or such other equivalent experience as may be approved by the board and who has met all the other requirements set forth by Section 021 of this rule but who has not yet passed the examination conducted by the Commission on Dietetic Registration. (4-2-03)

02. Provisional License Dietitian/Monitor Affidavit. The provisionally licensed graduate dietitian must obtain ~~A~~an affidavit signed by an Idaho licensed dietitian affirming and attesting to be responsible for the activities of the provisionally licensed graduated dietitian being supervised and to review and countersign all patient documentation performed by the provisionally licensed graduate dietitian being supervised. *(4-2-03)*( )

03. Supervision by Monitor. The practice or provision of dietetics by a graduate dietitian holding a provisional license to practice dietetics shall be in direct association with an Idaho licensed dietitian who shall be responsible for the activities of the provisionally licensed graduate dietitian being supervised and shall review and countersign all patient documentation performed by the provisionally licensed graduate dietitian. The supervising monitor need not be physically present or on the premises at all times but must be available for telephonic consultation. The extent of communication between the monitor and the provisionally licensed graduate dietitian shall be determined by the competency of the individual, the treatment setting, and the diagnostic category of the patients. (4-2-03)

(BREAK IN CONTINUITY OF SECTIONS)

032. DENIAL OR REFUSAL TO RENEW, SUSPENSION OR REVOCATION OF LICENSE.

01. Disciplinary Authority. A new or renewal application may be denied or a license may be suspended or revoked by the Board, and every person licensed pursuant to Title 54, Chapter 35, Idaho Code and these rules is subject to disciplinary actions or probationary conditions pursuant to the procedures and powers established by and set forth in Section 54-3505, Idaho Code, IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General," and IDAPA 22.01.07, "Rules of Practice and Procedure of the Board of Medicine." (3-20-14)

02. Grounds for Discipline. *In addition to the grounds set forth in Section 54-3510, Idaho Code, applicants may be refused licensure and licensees are subject to discipline upon the following grounds, including but not limited to* In addition to statutory grounds for discipline set forth in Section 54-3510, Idaho Code, every person licensed or provisionally licensed as a dietitian is subject to discipline by the Board under the following grounds: *(12-28-94)*( )

a. Being guilty of unprofessional conduct, including the provision of care which fails to meet the standard of care provided by other qualified licensees within the state of Idaho. (12-28-94)

b. Violating any provisions of this act or any of the rules promulgated by the Board under the authority of the act. (12-28-94)

c. Being convicted of a crime which may or would have a direct and adverse bearing on the licensee's ability to practice dietetics; (3-27-13)

d. Demonstrating a manifest incapacity to carry out the functions of the licensee's ability to practice dietetics or deemed unfit by the Board to practice dietetics; (3-27-13)

e. Using any controlled substance or alcohol which may or would have a direct and adverse bearing on the licensee's ability to practice dietetics; (3-27-13)

f. Misrepresenting educational or experience attainments; (3-27-13)

g. Failing to maintain adequate dietetic records. Adequate dietetic records mean legible records that contain subjective information, an evaluation or report of objective findings, assessment or diagnosis, and the plan of care; (3-27-13)

h. ~~*Failure*~~ Failing to monitor and be responsible for the activities of the provisionally licensed graduate dietitian; ~~*(3-27-13)*~~( )

i. Employing, directing or supervising the unlicensed practice of dietetics; (3-27-13)

j. Practicing in an area of dietetics for which the licensee is not trained; (3-27-13)

k. ~~*Commission of*~~ Committing any act of sexual contact, misconduct, exploitation, or intercourse with a patient or former patient or related to the licensee's practice of dietetics~~.~~: ~~*(3-27-13)*~~( )

i. Consent of the patient shall not be a defense; ( )

ii. Subsection 032.02 does not apply to sexual contact between a dietitian and the dietitian's spouse or a person in a domestic relationship who is also a patient; ( )

iii. A former patient includes a patient for whom the dietitian has provided dietetic services within the last twelve (12) months; ( )

iv. Sexual or romantic relationships with former patients beyond that period of time may also be a violation if the dietitian uses or exploits the trust, knowledge, emotions or influence derived from the prior professional relationship with the patient; ( )

l. Failing to report to the Board any known act or omission of a licensee, applicant, or any other person, that violates any of the rules promulgated by the Board under the authority of the act; (3-27-13)

m. Interfering with an investigation or disciplinary proceeding by willful misrepresentation of facts or by use of threats or harassment against any patient or witness to prevent them from providing evidence in a disciplinary proceeding, investigation or other legal action; (3-27-13)

n. ~~*Failure*~~ Failing to obey federal and local laws and rules governing the practice of dietetics; or ~~*(3-27-13)*~~( )

o. ~~*Failure*~~ Failing to be lawfully present in the United States. ~~*(3-27-13)*~~( )

033. DISCIPLINARY SANCTIONS.

01. Sanctions. As stated in Section 54-3510A, Idaho Code, if grounds for discipline are found to exist, the Board of Medicine, upon the recommendation of the licensure board, may issue an order to: ( )

a. Revoke the dietitian's license to practice dietetics; ( )

b. Suspend or restrict the dietitian's license to practice dietetics; and/or ( )

c. Impose conditions or probation upon the dietitian's license to practice dietetics. ( )

03~~3~~4. -- 040. (RESERVED)

041. FEES.
Actual fees shall be set to reflect costs of Board administration. (12-28-94)

01. Initial/Provisional Licensure and Examination Fee. The fee for initial licensure and examination shall be no more than one hundred fifty dollars ($150). (3-27-13)

02. Renewal Fee. The ~~annual~~ renewal fee shall be no more than one hundred dollars ($100) per year. ~~(3-27-13)~~( )

03. Reinstatement Fee. The reinstatement fee for a lapsed license shall be the annual renewal fee for each year of the two (2) years not licensed plus a fee of no more than fifty dollars ($50). Lapsed licenses not reinstated after two (2) years shall be canceled. (3-27-13)

04. Inactive Fee. The fee for inactive licensure shall be no more than fifty dollars ($50). (3-27-13)

05. Inactive to Active License Fee. An inactive license may be converted to an active license by application to the Board and payment of required fees. (4-2-03)

a. The fee for converting an inactive license to a~~n~~ license shall be a fee of no more than fifty dollars ($50) and the ~~annual~~ renewal fee for each year not actively licensed minus inactive fees previously paid. ~~(3-27-13)~~( )

b. Before the license will be converted, the applicant must account for the time during which an inactive license was held. The Board, in its discretion, may require a personal interview. (4-2-03)

06. Application Fees and Refunds. Necessary fees shall accompany applications. Fees shall not be refundable. (4-2-03)

07. Extraordinary Expenses. In situations where the processing of an application or a change in status requires extraordinary expenses, the Board will charge the applicant with reasonable fees to cover all the extraordinary expenses. (3-27-13)

~~**042. -- 049. (RESERVED)**~~

~~**050. EFFECTIVE DATE.**~~
~~These rules shall be effective, December 28, 1994.~~ ~~(12-28-94)~~

05~~1~~42. -- 999. (RESERVED)

IDAPA 23 – BOARD OF NURSING

23.01.01 – RULES OF THE IDAHO BOARD OF NURSING

DOCKET NO. 23-0101-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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(13), 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 6, 2017 Idaho Administrative Bulletin, **Vol. 17-9, pages 243 through 250**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Sandra Evans, Executive Director, at (208) 577-2482 or at **sandra.evans@ibn.idaho.gov**.

DATED this 3rd day of October, 2017.

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 83720-0006
Phone: (208) 577-2482
Fax: (208) 334-3262
E-mail: **sandra.evans@ibn.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 54-1404(13), 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 20, 2017.

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 current Board of Nursing rule that addresses when limited licenses are appropriate and how they are processed is not as clear as it should be and needs streamlining to eliminate an unwarranted step. Furthermore, the existing rule places an unnecessary restriction on otherwise qualified faculty members in nursing educational programs. Board of Nursing Rule 132 will be amended to clarify that, in applicable cases, such as disability due to substance use disorder or mental health disorder, the existing license may be converted to a limited license for a period not to exceed five (5) years, rather than the current process of requiring that the nurse first voluntarily surrender the existing license for the limited license to then be issued. The rulemaking will also amend Board Rules 640 and 643 to clarify requirements for nursing program faculty and remove an unneeded restriction currently imposed on would-be nursing program faculty.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules – Negotiated Rulemaking was published in the July 5, 2017 Idaho Administrative Bulletin, **Vol. 17-7, page 74**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, Executive Director, at (208) 577-2482 or at **sandra.evans@ibn.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 27, 2017.

DATED this 28th day of July, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-1701

132. LIMITED LICENSES.
Limited licenses may be issued to qualified individuals in four (4) categories: post-discipline, non-practicing status, restricted status, and substance use and mental health disorders. Failure to comply with the terms and conditions of a limited license will be cause for summary suspension. (3-24-17)

01. Following Disciplinary Action. (3-30-07)

a. After evaluation of an application for licensure reinstatement, the Board may issue a limited license to a nurse whose license has been revoked. (3-15-02)

b. The Board shall specify the conditions of issuance of the limited license in writing. The conditions may be stated on the license. (3-15-02)

02. Non-Practicing Status. (3-15-02)

a. Individuals who are prevented from engaging in the active practice of nursing may be issued a limited license. (3-15-02)

b. The Board shall specify that the license being issued does not entitle the licensee to engage in the active practice of nursing. The non-practicing status shall be noted on the license. (3-15-02)

c. The non-practicing limitation may be removed by the Board following receipt and evaluation of evidence satisfactory to the Board confirming that the licensee's physical or mental health status no longer prevents the individual from engaging in the active practice of nursing. (3-15-02)

03. Restricted Status. (3-15-02)

a. Individuals whose disabilities restrict or inhibit their ability to provide a full range of nursing services may be issued a limited license. (3-15-02)

b. In order to determine the appropriate limitations, the Board may evaluate statements from qualified professional persons who have personal knowledge of the applicant or licensee. The Board may also evaluate job descriptions and statements from potential employers and consider input from the applicant for the limited license. (3-15-02)

c. The Board shall specify the conditions of issuance of the limited license in writing. The conditions may be stated on the license. The conditions may include, but are not limited to: (3-15-02)

i. Notifying the Board of changes in employment status. (3-15-02)

ii. Submission of regular reports by the employer or by such other entities or individuals as the Board may desire. (3-15-02)

iii. Meeting with Board representatives. (3-15-02)

iv. Specific parameters of practice, excluding the performance of specific nursing functions. (3-15-02)

d. The conditions of limited practice may be removed by the Board following receipt and evaluation of satisfactory evidence confirming that the health status of the licensee no longer restricts or inhibits the person's ability to provide a full range of nursing services. (3-15-02)

04. Disability Due to Substance Use Disorder or Mental Health Disorder. (3-24-17)

a. Individuals whose practice is or may be impaired due to substance use disorder or to mental health disorder may qualify for issuance of a limited license as an alternative to discipline. (3-24-17)

b. The executive director may ~~*issue a limited*~~ restrict the license ~~*for a period not to exceed five (5) years to*~~ of an individual who ~~*voluntarily surrenders his license by reason of*~~ has a substance use disorder or ~~*relating to*~~ mental health disorder for a period not to exceed five (5) years and who: ~~*(3-24-17)*~~( )

i. Holds a current license to practice in Idaho as a registered nurse, advanced practice registered nurse, or licensed practical nurse, or is otherwise eligible, and is in the process of applying for licensure; (3-24-17)

ii. Has a demonstrated or diagnosed substance use disorder or mental health disorder such that ability to safely practice is, or may be, impaired; (3-24-17)

iii. Sign a written statement admitting to all facts which may constitute grounds for disciplinary action or demonstrate impairment of the safe practice of nursing, and waiving the right to a hearing and all other rights to due process in a contested case under the Idaho Administrative Procedures Act and the Nursing Practice Act; and (3-15-02)

iv. Submit reliable evidence, satisfactory to the executive director, that he is competent to safely practice nursing before being authorized to return to active practice. ~~*(3-15-02)*~~( )

c. If required, the applicant shall satisfactorily complete a treatment program accepted by the Board. (3-30-07)

d. The applicant must agree to participation in the Board's monitoring program to include: (3-15-02)

i. Evaluation and diagnosis of the disorder; (3-24-17)

ii. Approval of treatment program regimen; (5-21-89)

iii. Monitoring of progress; (5-21-89)

iv. Determination of when return to the workplace will be allowed. (7-1-96)

e. Admission to the Program for Recovering Nurses or issuance of a limited license, or both, may be denied for any reason including, but not limited to the following: (3-15-02)

i. The applicant diverted controlled substances for other than self-administration; or (3-15-02)

ii. The applicant creates too great a safety risk; or (3-15-02)

iii. The applicant has been terminated from this, or any other, alternative program for non-compliance. (3-15-02)

f. Upon satisfactory compliance with all of the terms of the limited license, and provided that the licensee demonstrates that he is qualified and competent to practice nursing, the executive director shall ~~*reinstate*~~ lift the ~~*renewable nursing license voluntarily surrendered*~~ restriction imposed. ~~*(3-30-07)*~~( )

05. Compliance Required. Limited licensure shall be conditioned upon the individual's prompt and faithful compliance with terms and conditions, which may include: (3-24-17)

a. Satisfactory progress in any required continuing treatment or rehabilitation program. (3-15-02)

b. Regular and prompt notification to the Board of changes in name and address of self or any

employer. (7-1-96)

c. Obtaining of performance evaluations prepared by the employer to be submitted at specified intervals and at any time upon request. (7-1-96)

d. Continuing participation in, and compliance with all recommendations and requirements of, the approved treatment or rehabilitation program, and obtaining of reports of progress submitted by the person directing the treatment or rehabilitation program at specified intervals and at any time upon request. (7-1-96)

e. Submission of self-evaluations and personal progress reports at specified intervals and at any time upon request. (3-24-17)

f. Submission of reports of supervised random alcohol/drug screens at specified intervals and at any time upon request. Participant is responsible for reporting as directed, submitting a sufficient quantity of sample to be tested, and payment for the screening. (7-1-96)

g. Meeting with the Board's professional staff or advisory committee at any time upon request. (3-24-17)

h. Working only in approved practice settings. (7-1-96)

i. Authorization by licensee of the release of applicable records pertaining to assessment, diagnostic evaluation, treatment recommendations, treatment and progress, performance evaluations, counseling, random chemical screens, and after-care at periodic intervals as requested. (7-1-93)

j. Compliance with all laws pertaining to nursing practice, all nursing standards, and all standards, policies and procedures of licensee's employer relating to any of the admitted misconduct or facts as set out in the written statement signed by licensee, or relating to the providing of safe, competent nursing service. (3-24-17)

k. Compliance with other specific terms and conditions as may be required by the executive director. (3-15-02)

06. Summary Suspension - Lack of Compliance. (3-30-07)

a. Summary Suspension. Any failure to comply with the terms and conditions of a limited license shall be deemed to be an immediate threat to the health, safety, and welfare of the public and the executive director shall, upon receiving evidence of any such failure, summarily suspend the limited license. (3-30-07)

i. Summary suspension of a limited license may occur if, during participation in the program, information is received which, after investigation, indicates the individual may have violated a provision of the law or Board rules governing the practice of nursing. (3-30-07)

ii. Upon summary suspension of a limited license, the executive director shall provide prompt written notice to the licensee stating the reason for the suspension, setting forth the evidence relied upon and notifying the licensee of his right to a hearing upon request at the earliest possible date in accordance with Section 54-1413(3)(a), Idaho Code. (3-30-07)

b. Right to Hearing. An individual whose limited license has been summarily suspended by the executive director may request a hearing regarding the suspension by certified letter addressed to the Board. If the individual fails to request a hearing within twenty (20) days after service of the notice of suspension by the executive director, the right to a hearing is waived. If a hearing is timely requested, after the hearing the Board shall enter an order affirming or rejecting summary suspension of the limited license and enter such further orders revoking, suspending, or otherwise disciplining the nursing license as may be necessary. The above provisions do not limit or restrict the right of Board staff to bring any summary suspension order before the Board for further proceedings, even if the licensee has not requested a hearing. (4-2-08)

c. Other Orders. The Board may, for good cause, stay any order of the executive director or may

modify the terms and conditions of a limited license as deemed appropriate to regulate, monitor or supervise the practice of any licensee. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

640. FACULTY QUALIFICATIONS.

01. Programs for Unlicensed Assistive Personnel. Primary instructors shall be approved by the Board and shall have: (4-5-00)

a. A current unencumbered license to practice as a registered nurse in this state; (4-5-00)

b. Evidence of three (3) years experience working as a registered nurse; (4-5-00)

c. Evidence of two (2) years experience in caring for the elderly or chronically ill of any age; and (4-5-00)

d. Evidence of completion of a course in methods of instruction or a Train-the-Trainer type program. (4-5-00)

e. Licensed practical nurses with a minimum of two (2) years experience in caring for the elderly or chronically ill of any age may assist with skills supervision under the supervision of an approved primary instructor. (4-5-00)

02. Practical Nurse Program Faculty Qualifications. Nursing faculty who have primary responsibility for planning, implementing, and evaluating curriculum in a program leading to licensure as a practical nurse shall have: (4-5-00)

a. A current, unencumbered license to practice as a registered nurse in this state; (4-5-00)

b. A minimum of a baccalaureate degree with a major in nursing; and (4-5-00)

c. Evidence of nursing practice experience. (4-5-00)

03. Registered Nurse Program Faculty Qualifications. There shall be sufficient faculty to achieve the purpose of the program. (4-5-00)

a. Nursing faculty who have primary responsibility for planning, implementing, and evaluating curriculum in a program leading to licensure as a registered nurse shall have: (4-5-00)

i. A current, unencumbered license to practice as a registered nurse in this state; (4-5-00)

ii. A minimum of a master's degree with a major in nursing; and (4-5-00)

iii. Evidence of nursing practice experience. (4-5-00)

b. Additional support faculty necessary to accomplish program objectives shall have: (4-5-00)

i. A current, unencumbered license to practice as a registered nurse in this state; (4-5-00)

ii. A minimum of a baccalaureate degree with a major in nursing; and (4-5-00)

iii. A plan approved by the Board for accomplishment of the master's of nursing within three (3) years of appointment to the faculty position. (4-5-00)

04. Advanced Practice Registered Nurse Program Faculty Qualifications. There shall be sufficient faculty to achieve the purpose of the program. Faculty who have primary responsibility for planning, implementing and evaluating curriculum in a program preparing individuals to license as an advanced practice registered nurse ~~program~~ shall have: ~~(4-5-00)~~( )

a. A current, unencumbered license to practice as a registered nurse in this state; and (4-5-00)

b. A ~~master's~~ graduate degree ~~and an earned doctoral~~ or post-graduate degree~~, one (1) of which is~~ in nursing; ~~or~~ ~~(4-5-00)~~( )

c. ~~A master's degree with a major in nursing and a~~An ~~appropriate~~ advanced practice registered nurse ~~credential~~ license and national certification if responsible for courses in a specific advanced practice registered nurse ~~category~~ role and population; and ~~(4-5-00)~~( )

d. Evidence of advanced registered nursing practice experience. ~~(4-5-00)~~( )

05. Non-clinical Nursing Courses Faculty Qualifications. Interprofessional faculty teaching non-clinical nursing course shall have advanced preparation appropriate for the content being taught. ( )

0~~5~~6. Clinical Preceptors in Registered Nurse, Practical Nurse, and Advanced Practice Registered Nurse Programs. Clinical preceptors may be used to enhance clinical learning experiences. (3-29-17)

a. Clinical preceptors in registered and practical nurse programs shall be licensed for nursing practice at or above the license role for which the student is preparing. (3-29-17)

b. Clinical preceptors in advanced practice registered nurse programs shall be licensed to practice as an advanced practice registered nurse (APRN), a physician (MD or DO), or a physician assistant (PA) in an area of practice relevant to the educational course objectives. (3-29-17)

c. Student-Preceptor ratio shall be appropriate to accomplishment of learning objectives; to provide for patient safety; and to the complexity of the clinical situation. (4-5-00)

d. Criteria for selecting preceptors shall be in writing. (4-5-00)

e. Functions and responsibilities of the preceptor shall be clearly delineated in a written agreement between the agency, the preceptor, and the educational program. (4-5-00)

f. The faculty shall be responsible to: (4-5-00)

i. Make arrangements with agency personnel in advance of the clinical experience, providing information such as numbers of students to be in the agency at a time, dates and times scheduled for clinical experience, faculty supervision to be provided, and arrange for formal orientation of preceptors. (4-5-00)

ii. Inform agency personnel of faculty-defined objectives and serve as a guide for selecting students' learning experiences and making assignments. (4-5-00)

iii. Monitor students' assignments, make periodic site visits to the agency, evaluate students' performance on a regular basis with input from the student and from the preceptor, and be available by telecommunication during students' scheduled clinical time. (4-5-00)

g. Provide direct supervision, by either a qualified faculty person or an experienced registered nurse employee of the agency, during initial home visits and whenever the student is implementing a nursing skill for the first time or a nursing skill with which the student has had limited experience. (4-5-00)

0~~6~~7. Continued Study. The parent institution will support and make provisions for continued professional development of the faculty. (7-1-91)

(BREAK IN CONTINUITY OF SECTIONS)

643. ADMINISTRATOR RESPONSIBILITIES AND QUALIFICATIONS.

01. Administrator Responsibilities. The administrator provides the leadership and is accountable for the administration, planning, implementation, and evaluation of the program. The administrator's responsibilities include, but are not limited to: (4-5-00)

a. Development and maintenance of an environment conducive to the teaching and learning processes; (4-5-00)

b. Liaison with and maintenance of the relationship with administrative and other units within the institution; (4-5-00)

c. Leadership within the faculty for the development and implementation of the curriculum; (4-5-00)

d. Preparation and administration of the program budget; (4-5-00)

e. Facilitation of faculty recruitment, development, performance review, promotion, and retention; (4-5-00)

f. Liaison with and maintenance of the relationship with the Board; and (4-5-00)

g. Facilitation of cooperative agreements with practice sites. (4-5-00)

02. Administrator Qualifications. The administrator of the program shall be a licensed registered nurse, with a~~n~~ current unencumbered license to practice in this state, and with the additional education and experience necessary to direct the program. ~~(4-5-00)~~( )

a. Programs for Unlicensed Assistive Personnel. Meet institutional requirements. (4-5-00)

b. Practical Nurse Administrator. The administrator in a program preparing for practical nurse licensure shall: (4-5-00)

i. Hold a minimum of a ~~master's~~ graduate degree with a major in nursing; and ~~(4-5-00)~~( )

ii. Have evidence of experience in education, administration, and practice sufficient to administer the program. (4-5-00)

c. Registered Nurse Administrator. The administrator in a program preparing for registered nurse licensure shall: (4-5-00)

i. Hold a minimum of a ~~master's~~ graduate with a major in nursing and meet institutional requirements; and ~~(4-5-00)~~( )

ii. Have evidence of experience in education, administration, and practice sufficient to administer the program. (4-5-00)

d. Advanced Practice Registered Nurse Administrator. The administrator in a program preparing for advanced practice registered nursing shall: (4-5-00)

i. Hold a ~~master's~~ graduate and ~~an earned doctoral~~ post-graduate degree, one of which is in nursing; and ~~(4-5-00)~~( )

ii. Have evidence of experience in education, administration, and practice sufficient to administer the program. (4-5-00)

03. Numbers of Administrators Needed. There shall be at least one (1) qualified nursing administrator for each nursing education department or division. In institutions that offer nursing education programs for more than one (1) level of preparation and where the scope of administrative responsibility so requires, there shall be an individual administrator for each nursing education program. (4-7-11)

IDAPA 24 – BUREAU OF OCCUPATIONAL LICENSES

24.12.01 – RULES OF THE IDAHO STATE BOARD OF PSYCHOLOGIST EXAMINERS

DOCKET NO. 24-1201-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 54-2305 and 54-5713, Idaho Code.

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

This proposed rule will ensure that temporary licensees hold a certification of prescriptive authority issued by the Board before issuing a prescription. It shortens the length of face-to-face supervision time required for category III service extenders, and it amends the telepsychology rules to refine the definition of telepsychology and clarify the informed consent provisions.

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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 360-366**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Dicsie Gullick at (208) 334-3233.

DATED this 22nd day of November, 2017.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W. State St.
P.O. Box 83720
Boise, ID 83720-0063
Phone: (208) 334-3233
Fax: (208) 334-3945

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 54-2305 and 54-5713, 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 18, 2017.

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

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

This proposed rule will ensure that temporary licensees hold a certification of prescriptive authority issued by the Board before issuing a prescription. It shortens the length of face-to-face supervision time required for category III service extenders, and it amends the telepsychology rules to refine the definition of telepsychology and clarify the informed consent provisions.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because 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: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dicsie Gullick at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1201-1701

300. TEMPORARY LICENSES (RULE 300).
Persons not licensed in this state who desire to practice psychology under the provisions of this chapter for a period not to exceed thirty (30) days within a calendar year may do so if they hold an interjurisdictional practice certificate (IPC) from the association of state and provincial psychology boards (ASPPB). As such, in order to practice temporarily under the IPC psychologists would be required to notify the Board of their intent to practice and provide documentation of their status. It is the IPC holders responsibility to contact the ASPPB to send verification of IPC status, including verification of no discipline. Persons authorized to practice under this section must hold a certification of prescriptive authority issued by the Idaho Board of Psychologist Examiners to issue a prescription.
~~(3-29-10)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

450. GUIDELINES FOR USE OF SERVICE EXTENDERS TO LICENSED PSYCHOLOGISTS (RULE 450).
The Board recognizes that licensed psychologists may choose to extend their services by using service extenders. The Board provides general rules to cover all service extenders as well as specific rules to cover service extenders with different levels of training and experience. (7-1-93)

01. General Provisions for Licensed Psychologists Extending Their Services Through Others. (7-1-93)

a. The licensed psychologist exercising administrative control for a service extender shall: (7-1-93)

i. Have the authority to cause termination of compensation for the service extender. (7-1-93)

ii. Have the authority to cause the suspension or removal of the service extender from his position as a service provider. (7-1-93)

b. The licensed psychologist exercising professional direction for a service extender shall: (7-1-93)

i. Prior to employing the service extender, formulate and provide to the Board a written supervisory plan for each service extender and obtain approval for the plan. The plan shall include provisions for supervisory sessions and chart review. If the psychologist requires tapes to be made of psychological services delivered by the service extender, then the plan shall also specify review and destruction of these tapes. The plan shall also specify the hours per calendar week that the licensed psychologist will be at the same physical location as the person extending the services of the licensed psychologist. The plan shall be accompanied by a completed application form and appropriate application fee. (3-29-17)

ii. Establish and maintain a level of supervisory contact sufficient to be readily accountable in the event that professional, ethical, or legal issues are raised. For service extenders in Categories I and II, ~~T~~there will be a minimum of one (1) hour of face-to-face supervisory contact by a licensed psychologist with the service extender for each one (1) to twenty (20) hours of services provided by the service extender during any calendar week. At least one half (1/2) of this face-to-face supervisory contact will be conducted individually, and up to one half (1/2) of this face-to-face supervisory contact may be provided using a group format. A written record of this supervisory contact, including the type of activities conducted by the service extender, shall be maintained by the licensed psychologist. Except under unusual circumstances, the supervisory contact will occur either during the week the services are extended or during the week following. In no case will services be extended more than two (2) weeks without supervisory contact between the service extender and a licensed psychologist. For service extenders in Category III,

there will be a minimum of one (1) hour of face-to-face supervisory contact by a licensed psychologist with the service extender during each calendar month that services are provided by the service extender. A written record of this supervisory contact, including the type of activities conducted by the service extender, shall be maintained by the licensed psychologist. The licensed psychologist will also be available for consultation either face-to-face, by phone, or by other means of contact on any day that services are provided by the service extender. ~~(7-1-93)~~( )

iii. Provide the service extender a copy of the current Ethical Standards of the American Psychological Association, and obtain a written agreement from the service extender of his intention to abide by them. (7-1-93)

c. Supervision of service extenders through electronic communications, including video conferencing, cannot replace face-to-face supervision. Psychologists will ensure that the service that they provide through the use of service extenders is provided according to all applicable laws and rules. (3-29-17)

02. Qualifications for Service Extenders. (7-1-93)

a. Category I: A service extender will be placed in Category I if: (7-1-93)

i. The licensed psychologist wishing to employ the service extender verifies in writing to the satisfaction of the Board that the service extender holds a license issued by the state of Idaho to practice a specific profession, and that the issuance of that license requires the licensee hold a master's degree or its equivalent as determined by the Board; or (7-1-93)

ii. The service extender meets the criteria for Category II specified below and the licensed psychologist wishing to employ the service extender verifies in writing to the satisfaction of the Board that the service extender has satisfactorily functioned as a service extender to one (1) or more licensed psychologist for at least twenty (20) hours per calendar week over a period totaling two hundred sixty (260) weeks. (7-1-93)

b. Category II: A service extender will be placed in Category II if the licensed psychologist wishing to employ the service extender verifies in writing to the satisfaction of the Board that the service extender holds a master's degree or equivalent from a program in psychology, counseling, or human development as determined by the Board. (3-29-17)

c. Category III: A service extender will be placed in Category III if the licensed psychologist wishing to employ the service extender verifies in writing to the satisfaction of the Board that the service extender holds a master's degree or equivalent from a program in psychology, counseling, or human development as determined by the Board, and the service extender will only provide psychometrician services. Such services are defined as administrating, scoring, and/or summarizing psychological or neuropsychological tests and test data that require specialized training. Interpretation of the testing data must be performed by the licensed psychologist. Service extenders in Category III will not be allowed to perform psychotherapy, intake assessments, or other services outside the scope of psychometric services defined above. The licensed psychologist wishing to employ the service extender must also verify in writing to the satisfaction of the Board that the service extender has been properly trained in all of the testing instruments that the service extender will administer at the start of employment and will continue to receive proper training in any new testing instruments utilized by the service extender over the course of employment. (3-29-17)

03. Conditions for Use of Service Extenders. (7-1-93)

a. All persons used to extend the services of a licensed psychologist shall be under the direct and continuing administrative control and professional direction of a licensed psychologist. These service extenders may not use any title incorporating the word "psychologist" or any of its variants or derivatives, e.g. "psychological," "psychotherapist." (5-8-09)

b. Work assignments shall be commensurate with the skills of the service extender and procedures shall be planned in consultation with the licensed psychologist under all circumstances. (7-1-93)

c. Public announcement of fees and services, as well as contact with lay or professional public shall be offered only in the name of the licensed psychologist whose services are being extended. However, persons

licensed to practice professions other than psychology may make note of their status in such announcements or contacts. (7-1-93)

d. Setting and collecting of fees shall remain the sole domain of the licensed psychologist; excepting that when a service extender is used to provide services of the licensed psychologist, third party payers shall be informed of this occurrence in writing at the time of billing. Unless otherwise provided in these rules and regulations, licensed psychologists may neither claim or imply to service recipients or to third party payers an ability to extend their services through any person who has not been approved as a service extender to that psychologist as specified in this section. (7-1-93)

e. All service recipients shall sign a written notice of the service extender's status as a service extender for the licensed psychologist. A copy of the signed written notice will be maintained on file with the licensed psychologist. (7-1-93)

f. Within the first three (3) contacts, the licensed psychologist shall have face-to-face contact with each service recipient. (7-1-93)

g. A licensed psychologist shall be available to both the service extender and the service recipient for emergency consultation. (7-1-93)

h. Service Extenders shall be housed in the same service delivery site as the licensed psychologist whose services they extend. Whatever other activities they may be qualified to perform, service extenders shall limit themselves to acting as service extenders of the licensed psychologist when providing direct services so long as they are physically located in the offices of the licensed psychologist. (7-1-93)

i. A service extender in Category I may deliver as much as, but not more than fifty percent (50%) of their service while the licensed psychologist is not physically present at the service delivery site. A service extender in Category II may deliver as much as, but not more than twenty-five percent (25%) of their service while the licensed psychologist is not physically present at the service delivery site. Service extenders in the Category III may deliver as much as, but not more than seventy-five percent (75%) of their service while the licensed psychologist is not physically present at the service delivery site. Service Extenders providing as many as, but no more than, three (3) hours of service extension per calendar week shall be exempted from the on-site provisions of Section 450 of this rule. Without notification to the Board, short term exemption from this rule for atypical circumstances, such as irregular travel by the licensed psychologist, may occur for periods as long as, but no longer than three (3) calendar weeks. Longer exemptions may be granted at the discretion of the Board on written request by the licensed psychologist to the Board. (3-29-17)

j. The licensed psychologist shall employ no more than three (3) service extenders. (3-18-99)

k. When a licensed psychologist terminates employment of a service extender, the licensed psychologist will notify the Board in writing within thirty (30) days. (7-1-93)

l. At the time of license renewal the licensed psychologist shall submit for each service extender the appropriate fee together with certification to the Board that they possess: (3-19-07)

i. A written record of supervisory contact for the previous twelve (12) months; and (3-20-04)

ii. The percentage of time during the previous twelve (12) months that the service extender extended services while the licensed psychologist was at the service delivery site; and (3-20-04)

iii. An updated plan for the supervision of each of his service extenders. (3-20-04)

m. Documentation of supervisory notes, hours of supervision, number of hours on-site while the service extender provided services, and plan of supervision shall be maintained by the supervisor for not less than three (3) years for each service extender and submitted to the Board upon request. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

601. TELEPSYCHOLOGY.
This rule supplements Title 54, Chapter 57, Idaho Code, the Idaho Telehealth Access Act, the American Psychological Association Guidelines for the Practice of Telepsychology, and all other laws and rules applicable to the practice of telepsychology in this state. (3-29-17)

01. Definitions. For purposes of telepychology services, the following terms are defined as follows: (3-29-17)

a. Emergency. Emergency means a situation in which there is an occurrence that poses an imminent threat of a life threatening condition or severe bodily harm. (3-29-17)

b. Information Technology. Information technology means the production, storage, and communication of information using computers and microelectronics including but not limited to telephones, mobile devices, interactive videoconferencing, email, chat, text, social media, and other Internet based services. (3-29-17)

c. Telehealth Provider. Telehealth provider means a person who is licensed, required to be licensed, or, if located outside of Idaho, would be required to be licensed if located in Idaho by Title 54, Chapter 23, Idaho Code and who provides or offers to provide telepsychology services to persons who are located in or who reside in Idaho. (3-29-17)

d. Telepsychology Services. Telepsychology services mean psychological services provided ~~*to a person through the use of information technology for the purpose of assessing, testing, diagnosing, treating, educating, or consulting. Telepsychology services may be synchronous or asynchronous*~~ by a provider through the use of electronic communications, information technology, asynchronous store and forward transfer of information or synchronous interaction between the provider at a distant site and a service recipient at an originating site. Such services include, but are not limited to, assessing, testing, diagnosing, treating, educating, and consulting.
~~*(3-29-17)*~~( )

02. General. (3-29-17)

a. When telepsychology services are contemplated, a telehealth provider will document individualized potential benefits and potential risks to the service recipient(s). (3-29-17)

b. Before telepsychology services are provided, a telehealth provider will document an emergency plan in the service recipient's record. The plan will specify the procedure for dealing with emergencies that will in an effective and timely way, provide for the service recipient's welfare. (3-29-17)

c. Except for psycho-educational purposes, the use of avatars for telepsychology services is prohibited. (3-29-17)

03. Initial Contact. Telehealth providers will, upon initial contact with the service recipient except in an emergency, prior to providing telepsychology services, obtain the written, informed consent of the service recipient(s), consistent with accepted professional and legal requirements concerning: ( )

a. The limitations and challenges of using information technology to provide telepsychology services; ( )

b. The potential for breaches in confidentiality of information while delivering telepsychology services; ( )

c. The risks of sudden and unpredictable disruption of telepsychology services and the alternative means by which communication may be re-established. ( )

0~~3~~4. Informed Consent.Telehealth providers will, upon initial and subsequent contact with the service recipient: (3-29-17)

a. Make reasonable efforts to verify the identity of the service recipient; (3-29-17)

b. Provide to the service recipient alternative means of contacting the telehealth provider should communications be disrupted during the provision of services. (3-29-17)

~~*c. Except in an emergency, prior to providing telepsychology services, obtain the written, informed consent of the service recipient(s), consistent with accepted professional and legal requirements concerning:*~~ ~~*(3-29-17)*~~

~~*i. The limitations and challenges of using information technology to provide telepsychology services;*~~ ~~*(3-29-17)*~~

~~*ii. The potential for breaches in confidentiality of information while delivering telepsychology services;*~~ ~~*(3-29-17)*~~

~~*iii. The risks of sudden and unpredictable disruption of telepsychology services and the alternative means by which communication may be re-established;*~~ ~~*(3-29-17)*~~

~~*d*~~**c.** Discuss who, in addition to the provider and the service recipient, may have access to the content of telecommunications between the provider and service recipient; (3-29-17)

~~*e*~~**d.** Inform the service recipient of when and how the provider will respond to electronic messages; (3-29-17)

~~*f*~~**e.** Ensure that a written agreement has been executed with service recipient(s) concerning compensation, billing, and payment arrangements. (3-29-17)

0~~4~~5. Security and Confidentiality. Telehealth providers must: (3-29-17)

a. Use secure communications when providing telepsychology services ~~*whenever feasible*~~ and document consent for the use of non-secure communication means when they are necessary; ~~*(3-29-17)*~~( )

b. Document how electronic communications are stored and maintain confidentiality of communications with service recipients; (3-29-17)

c. Ensure that unauthorized persons cannot recover or access confidential electronically-stored information when retained by the provider and after the data or equipment in which the data is stored has been discarded. (3-29-17)

d. Inform service recipients how electronic communications may be sent to the provider and how the provider will store these communications. (3-29-17)

0~~5~~6. Assessment. (3-29-17)

a. When conducting psychological assessments using telepsychology services, telehealth providers must only use test and assessment procedures that are empirically supported for the patient population being evaluated. (3-29-17)

b. Telehealth providers using telepsychology for assessment must ensure that the identity of service recipients remains secure, that test security is maintained, that test-taking conditions are conducive to quiet and private test administration, and that the parameters of the test(s) are not compromised. (3-29-17)

c. Telehealth providers will explain to service recipients the potential limitations of conclusions and recommendations drawn from the results on online assessments and will document these limitations in the findings or report. Treatment will not be based solely upon the results of online assessments. (3-29-17)

06~~6~~7. Interjurisdictional Practice. (3-29-17)

a. Before delivering telepsychology services to recipients across state, territorial, and international boundaries, telehealth providers should familiarize themselves and ensure that they comply with all applicable laws. (3-29-17)

b. Telehealth providers who are licensed to practice psychology pursuant to Title 54, Chapter 23, Idaho Code are under the jurisdiction of the Board when providing telepsychology services to Idaho residents located either within or outside of Idaho and to all recipients located within the state of Idaho. (3-29-17)

c. Except when providing telepsychology services in response to an emergency, telehealth providers who are not licensed to practice psychology in this state, who do not hold a temporary license under Section 300, or who are not otherwise exempt by law, but who are nevertheless providing telepsychology services to recipients located in this state, are guilty of a misdemeanor crime under Chapter 23, Title 54, Idaho Code. (3-29-17)

IDAPA 24 – BUREAU OF OCCUPATIONAL LICENSES

24.13.01 – RULES GOVERNING THE PHYSICAL THERAPY LICENSURE BOARD

DOCKET NO. 24-1301-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 54-2206, Idaho Code.

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

This proposed rule outlines the number of hours of continuing education ("CE") required for reinstatement of a physical therapy license. This proposed rule requires 1 year of CE (or 16 hours) for licenses expired for one year or less; 2 years of CE (or 32 hours) for licenses expired for more than a year and up to 2 years; and 3 years of CE (or 48 hours) for licenses expired for more than 2 years.

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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 367-370**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Dicsie Gullick at (208) 334-3233.

DATED this 22nd day of November, 2017.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W. State St.
P.O. Box 83720
Boise, ID 83720-0063
Phone: (208) 334-3233
Fax: (208) 334-3945

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 54-2206, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 18, 2017.

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

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

This proposed rule outlines the number of hours of continuing education ("CE") required for reinstatement of a physical therapy license. This proposed rule requires 1 year of CE (or 16 hours) for licenses expired for one year or less; 2 years of CE (or 32 hours) for licenses expired for more than a year and up to 2 years; and 3 years of CE (or 48 hours) for licenses expired for more than 2 years.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because 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: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dicsie Gullick at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 31st day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1301-1701

250. CONTINUING EDUCATION REQUIREMENT (RULE 250).

01. Renewal of License. ~~*On and after January 1, 2008, e*~~Every person holding a license issued by the Board must annually complete sixteen (16) contact hours of continuing education prior to license renewal. ~~*(3-19-07)*~~( )

02. Reinstatement of License. Any license cancelled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code, with the exception that the applicant shall submit proof of having met the following continuing education requirement: ( )

a. For licenses expired for one (1) year or less, one (1) year of continuing education; ( )

b. For licenses expired for more than one (1) year and up to two (2) years, two (2) years of continuing education; ( )

c. For licenses expired for more than two (2) years, three (3) years of continuing education. ( )

0~~1~~3. **Contact Hours**. The contact hours of continuing education shall be obtained in areas of study germane to the practice for which the license is issued as approved by the board. (3-19-07)

0~~2~~4. **Documentation of Attendance**. It shall be necessary for the applicant to provide documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be maintained by the licensee and provided to the board upon request by the board or its agent. (3-19-07)

0~~3~~5. **Excess Hours**. Continuing education hours accumulated during the twelve (12) months immediately preceding the license expiration date may be applied toward meeting the continuing education requirement for the next license renewal. Hours in excess of the required hours may be carried forward. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) time. (3-19-07)

0~~4~~6. **Compliance Audit**. The board may conduct random continuing education audits of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the board of meeting the continuing education requirement be submitted to the bureau. Failure to provide proof of meeting the continuing education upon request of the board shall be grounds for disciplinary action. (3-19-07)

0~~5~~7. **Special Exemption**. The board shall have authority to make exceptions for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must provide any information requested by the board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the board. (3-19-07)

0~~6~~8. **Continuing Education Credit Hours**. Hours of continuing education credit may be obtained by attending and participating in a continuing education activity approved by the Board. (3-19-07)

a. General Criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit: (3-19-07)

i. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee; (3-19-07)

ii. Pertains to subject matters integrally related and germane to the practice of the profession;

(3-19-07)

iii. Conducted by individuals who have specialized education, training and experience to be considered qualified to present the subject matter of the program. The Board may request documentation of the qualifications of presenters; (3-19-07)

iv. Application for Board approval is accompanied by a paper, manual or outline which describes the specific offering and includes the program schedule, goals and objectives; and (3-19-07)

v. Provides proof of attendance to licensees in attendance including: Date, location, course title, presenter(s); Number of program contact hours (One (1) contact hour equals one (1) hour of continuing education credit.); and the official signature or verification of the program sponsor. (3-19-07)

b. Specific Criteria. Continuing education hours of credit may be obtained by: (3-19-07)

i. Presenting professional programs which meet the criteria listed in these rules. Two (2) hours of credit will be awarded for each hour of presentation by the licensee. A course schedule or brochure must be maintained for audit; (3-19-07)

ii. Providing official transcripts indicating successful completion of academic courses which apply to the field of physical therapy in order to receive the following continuing education credits: (3-19-07)

(1) One (1) academic semester hour = fifteen (15) continuing education hours of credit; (3-19-07)

(2) One (1) academic trimester hour = twelve (12) continuing education hours of credit; (3-19-07)

(3) One (1) academic quarter hour = ten (10) continuing education hours of credit. (3-19-07)

iii. Attending workshops, conferences, symposiums or electronically transmitted, live interactive conferences which relate directly to the professional competency of the licensee; (3-19-07)

iv. Authoring research or other activities which are published in a recognized professional publication. The licensee shall receive five (5) hours of credit per page; (3-19-07)

v. Viewing videotaped presentations if the following criteria are met: (3-19-07)

(1) There is a sponsoring group or agency; (3-19-07)

(2) There is a facilitator or program official present; (3-19-07)

(3) The program official may not be the only attendee; and (3-19-07)

(4) The program meets all the criteria specified in these rules; (3-19-07)

vi. Participating in home study courses that have a certificate of completion; (3-19-07)

vii. Participating in courses that have business-related topics: marketing, time management, government regulations, and other like topics; (3-19-07)

viii. Participating in courses that have personal skills topics: career burnout, communication skills, human relations, and other like topics; (4-7-11)

ix. Participating in courses that have general health topics: clinical research, CPR, child abuse reporting, and other like topics; (3-29-12)

x. Supervision of a physical therapist student or physical therapist assistant student in an accredited college program. The licensee shall receive four (4) hours of credit per year; and (3-29-12)

xi. Completion and awarding of Board Certification or recertification by American Board of Physical Therapy Specialists (ABPTS). The licensee shall receive sixteen (16) hours for the year the certification or recertification was received. (3-29-12)

0~~7~~9. Course Approval. Courses of study relevant to physical therapy and sponsored or provided by the following entities or organizations shall be approved for continuing education credits: (3-29-12)

a. The American Physical Therapy Association (APTA) or any of its sections or local chapters; or (3-29-12)

b. The Federation of State Boards of Physical Therapy (FSBPT); or (3-29-12)

c. Commission on Accreditation in Physical Therapy Education (CAPTE); or (3-29-12)

d. National Athletic Trainers Association (NATA); or (3-29-12)

e. A College or University which is accredited or a candidate for accreditation by the Northwest Association of Secondary and Higher Schools or any similar accrediting body; or (3-29-12)

f. Otherwise approved by the Board. (3-29-12)

0~~8~~10. Submitting False Reports or Failure to Comply. The Board may condition, limit, suspend, or refuse to renew the license of any individual whom the Board determines submitted a false report of continuing education or failed to comply with the continuing education requirements. (3-19-07)

~~09~~11. Failure to Receive the Renewal Application. Failure to receive the renewal application shall not relieve the licensee of the responsibility of meeting the continuing education requirements and submitting the renewal application and renewal fee. (3-19-07)

IDAPA 24 – BUREAU OF OCCUPATIONAL LICENSES

24.23.01 – RULES OF THE SPEECH, HEARING AND COMMUNICATION SERVICES LICENSURE BOARD

DOCKET NO. 24-2301-1701

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2018 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 Sections 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 54-2910, Idaho Code.

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

The pending rule clarifies that the practice of audiology does not include the operation of automated newborn hearing screening machines. It also increases flexibility for licensees in completing continuing education (CE) by moving from a 1-year CE cycle (completion of 10 hours of CE within a one-year period) to a 3-year CE cycle (completion of 30 hours of CE within a three-year period).

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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 374-376**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Dicsie Gullick at (208) 334-3233.

DATED this 22nd day of November, 2017.

Tana Cory, Bureau Chief
Bureau of Occupational Licenses
700 W. State St.
P.O. Box 83720
Boise, ID 83720-0063
Phone: (208) 334-3233
Fax: (208) 334-3945

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 54-2910, 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 18, 2017.

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

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

This proposed rule clarifies that the practice of audiology does not include the operation of automated newborn hearing screening machines. It also increases flexibility for licensees in completing continuing education (CE) by moving from a 1-year CE cycle (completion of 10 hours of CE within a one-year period) to a 3-year CE cycle (completion of 30 hours of CE within a three-year period).

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because 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: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dicsie Gullick at (208) 334-3233.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 31st day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-2301-1701

212. NEWBORN HEARING SCREENING TESTS.
Performing newborn hearing screening tests on infants using automated equipment that produces a pass/fail response does not, by itself, constitute the practice of audiology or convert persons performing the tests into audiology support personnel. ( )

21~~2~~3. -- 219. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

400. CONTINUING EDUCATION (RULE 400).
~~*Every person holding an Idaho license pursuant to this act must annually complete ten (10) contact hours of continuing education prior to license renewal*~~ In order to protect public health and safety and promote the public welfare, the Board has adopted the following continuing education requirement of all licensees: ~~*(3-30-06)*~~( )

~~***01. Contact Hours**. The contact hours of continuing education shall be obtained in areas of study germane to the practice for which the license is issued as approved by the Board.* *(3-30-06)*~~

01. Requirement. Until January 1, 2021, each licensee will successfully complete, in the twelve (12) months preceding each renewal of their license, a minimum of ten (10) contact hours of continuing education. ( )

a. Effective January 1, 2021, each licensee will successfully complete, in the three (3) years prior to their license expiration date, a minimum of thirty (30) contact hours of continuing education. ( )

b. A contact hour is a measurement of the licensee's participation in an area of study germane to the practice for which the license is issued as approved by the Board. One (1) contact hour requires one (1) hour of participation in a Board-approved continuing education program excluding meals and breaks. One (1) contact hour equals one (1) clock hour for purposes of obtaining continuing education credit. ( )

c. For college or university courses that are approved by the Board for continuing education credit, one (1) semester credit hour equals fifteen (15) contact hours; one (1) quarter credit hour equals ten (10) contact hours. ( )

d. Effective January 1, 2021, the Board will waive the continuing education requirement for the first three (3) license renewals after initial licensure. ( )

02. Documentation of Attendance. It shall be necessary for the applicant to provide documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the applicant. This documentation must be maintained by the applicant and provided to the Board upon request by the Board or its agent. (3-30-06)

03. Compliance Audit. The Board may conduct random continuing education audits of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the Board of meeting the continuing education requirement be submitted to the Bureau. Failure to provide proof of meeting the continuing education upon request of the Board shall be grounds for disciplinary action in accordance with Section 54-2923, Idaho Code. (3-30-06)

04. Initial Compliance. Until January 1, 2021, ~~I~~licensees shall not be required to meet the continuing education requirement for the first renewal. ~~*(3-30-06)*~~( )

~~***05. Equivalence**. One (1) continuing education hour shall equal one (1) clock hour. (3-30-06)*~~

~~***06. Carryover of Continuing Education (CE) Hours**. Continuing education courses not claimed for CE credit in the current renewal year may be credited for the next renewal year. A maximum of five (5) hours may be carried forward from the immediately preceding year. (3-29-10)*~~

0~~7~~5. **Special Exemption**. The Board shall have authority to make exceptions for reasons of individual hardship, including health, when certified by a medical doctor, or other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board. Requests for special exemption must be received by the Bureau fifteen (15) business days prior to expiration of the license. (3-29-10)

IDAPA 27 – BOARD OF PHARMACY

27.01.01 – RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 27-0101-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 4, 2018 Idaho Administrative Bulletin, **Vol. 17-10, pages 392 through 393**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Alex Adams at (208) 334-2356.

DATED this 27th day of October, 2017.

Alex J. Adams, Pharm D, MPH
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: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Wednesday, October 25, 2017 – 9:00 a.m. (MDT)

Idaho State Capitol Building
Room WW53
700 West Jefferson Street
Boise, ID 83702

For those planning to attend the open public hearing, the Board will accept written and verbal comments. For all others not planning to attend the public hearing, written comments will be accepted by the Executive Director on or before close of business on October 24, 2017 as follows:

- Written comments received by October 20, 2017 will be included in the Board's distributed meeting material for consideration in advance of the hearing.
- Written comments received between October 21, 2017 and October 24, 2017 will be printed and provided to the Board at the open public hearing.

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

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

The rules of the Idaho State Board of Pharmacy, IDAPA 27, Title 01, Chapter 01, are being repealed in their entirety effective July 1, 2018. New rules are being promulgated as six separate chapters as indicated below. The Board does not intend to add any new regulatory requirements as part of its rulemaking; instead, as the Board better organizes its rules into chapters, it aims to simultaneously eliminate outdated regulations and those that stifle the emergence of new technology or new practice models that can improve public health and safety.

1. General Provisions (Docket No. 27-0101-1702)
2. Rules Governing Licensing and Registration (Docket No. 27-0102-1701)
3. Rules Governing Pharmacy Practice (Docket No. 27-0103-1701)
4. Rules Governing Pharmacist Prescriptive Authority (Docket No. 27-0104-1701)
5. Rules Governing Drug Compounding (Docket No. 27-0105-1701)
6. Rules Governing DME, Manufacturing, and Distribution (Docket No. 27-0106-1701)

Detailed descriptions of each of the aforementioned chapters accompany the referenced rule dockets.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted in two separate open, public meetings on August 1, 2017 and August 30, 2017. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2017 Idaho Administrative Bulletin, **Vol. 17-6, pages 54 through 56**, and in the August 2, 2017 Idaho Administrative Bulletin, **Vol.17-8, pages 114 through 115**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams 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 25, 2017.

DATED this 30th day of August, 2017.

LSO Rules Analysis Memo

IDAPA 27.01.01 IS BEING REPEALED IN ITS ENTIRETY

IDAPA 27 – BOARD OF PHARMACY

27.01.01 – GENERAL PROVISIONS

DOCKET NO. 27-0101-1702 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 rules are generally adopted as originally proposed. Section 023 was updated to reflect that the unprofessional conduct rule applies to any Board licensee or registrant.

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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 394 through 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: N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Alex Adams at (208) 334-2356.

DATED this 27th day of October, 2017.

Alex J. Adams, Pharm D, MPH
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: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Wednesday, October 25, 2017 – 9:00 a.m. (MDT)

Idaho State Capitol Building
Room WW53
700 West Jefferson Street
Boise, ID 83702

For those planning to attend the open public hearing, the Board will accept written and verbal comments. For all others not planning to attend the public hearing, written comments will be accepted by the Executive Director on or before close of business on October 24, 2017 as follows:

- Written comments received by October 20, 2017 will be included in the Board's distributed meeting material for consideration in advance of the hearing.
- Written comments received between October 21, 2017 and October 24, 2017 will be printed and provided to the Board at the open public hearing.

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

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

The scope of Chapter 27.01.01. is to establish general provisions for the Board of Pharmacy, and to serve as a parent chapter for all subsequent chapters. This chapter is comprised of current rules as follows: definitions and abbreviations, criteria for obtaining a waiver or variance, the Board's authority to inspect and investigate, and acts that constitute unprofessional conduct. Changes made to the current rules include:

- Definitions that merely duplicate those already defined in Sections 54-1705 and 37-2701, Idaho Code, are removed;
- Definitions are added for 'ACCME,' 'CLIA-Waived Test,' 'Clinical Guidelines,' 'CPE Monitor,' and 'Student Technician'; and
- Unprofessional conduct is expanded to include provisions related to 'Standard of Care' and 'Unnecessary Services or Products.'

These rules will take effect in their entirety on July 1, 2018.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted in two separate open, public meetings on August 1, 2017 and August 30, 2017. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published under Docket No. 27-0101-1701 in the June 7, 2017 Idaho Administrative Bulletin, **Vol. 17-6, pages 54-56**, and in the August 2, 2017 Idaho Administrative Bulletin, **Vol. 17-8, pages 114-115**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams 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 25, 2017.

DATED this 30th day of August, 2017.

LSO Rules Analysis Memo

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

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0101-1702

IDAPA 27
TITLE 01
CHAPTER 01

27.01.01 – GENERAL PROVISIONS

000. LEGAL AUTHORITY.
This chapter is adopted under the legal authority of the Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code; the Idaho Pharmacy Act, the Idaho Wholesale Drug Distribution Act, and the Idaho Legend Drug Donation Act, Title 54, Chapter 17, Idaho Code; and specifically pursuant to Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, and 54-1763, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. The title of this chapter is "General Provisions," IDAPA 27, Title 01, Chapter 01. ( )

02. Scope. The scope of this chapter includes, but is not limited to, provision for, and clarification of, the Board's assigned responsibility to: ( )

a. Regulate and control the manufacture, distribution, and dispensing of controlled substances within or into the state, pursuant to the Uniform Controlled Substances Act, Section 37-2715, Idaho Code; ( )

b. Regulate and control the practice of pharmacy, pursuant to the Idaho Pharmacy Act, Section 54-1718, Idaho Code; and ( )

c. Carry out its duties in regard to drugs, devices and other materials used in the diagnosis, mitigation and treatment, or prevention of injury, illness, and disease, pursuant to Section 54-1719, Idaho Code, or in regard to professionals or other individuals licensed or registered by the Board or otherwise engaged in conduct subject to regulation under these Acts. ( )

002. WRITTEN INTERPRETATIONS.
In accordance with Title 67, Chapter 52, Idaho Code, this agency may have written statements that pertain to the interpretation of, or to compliance with the rules of this chapter. Any such documents are available for public inspection and copying at cost at the Idaho Board of Pharmacy office. ( )

003. ADMINISTRATIVE PROCEEDINGS AND APPEALS.
Administrative proceedings and appeals are administered by the Board in accordance with the "Idaho Rules of Administrative Procedure of the Attorney General," IDAPA 04.11.01, Subchapter B -- Contested Cases, Rules 100 through 800. ( )

01. Place and Time for Filing. Documents in rulemakings or contested cases must be filed with the executive director of the Board at the Board office between the hours of 8 a.m. and 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

02. Manner of Filing. One (1) original of each document is sufficient for filing; however, the person or officer presiding over a particular rulemaking or contested case proceeding may require the filing of additional copies. A document may be filed with the Board by e-mail or fax if legible, complete, and received during the Board's office hours. The filing party is responsible for verifying with Board staff that an e-mail or fax was successfully and legibly received. ( )

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference into these rules. ( )

005. BOARD OFFICE INFORMATION.

01. Street Address. The office is located at 1199 Shoreline Lane, Suite 303, Boise, Idaho. ( )

02. Mailing Address. The mailing address is P.O. Box 83720, Boise, Idaho 83720-0067. ( )

03. Telephone Number. The telephone number is (208) 334-2356. ( )

04. Fax Number. The fax number is (208) 334-3536. ( )

05. Electronic Address. The website address is https://bop.idaho.gov. ( )

06. Office Hours. The office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

006. PUBLIC RECORDS ACT COMPLIANCE.
Board of Pharmacy records and filings are subject to compliance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. ( )

007. OFFICIAL BOARD JOURNAL.

The official journal of the Board is the electronic Idaho State Board of Pharmacy Newsletter. A link to recent versions of the newsletter is posted on the Board's website. Board licensees and registrants are presumed to have knowledge of the contents of the newsletter on the date of publication. The newsletter may be used in administrative hearings as proof of notification. ( )

008. – 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS (A -- D).
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the following terms shall have the meanings set forth below: ( )

01. ACCME. Accreditation Council for Continuing Medical Education. ( )

02. 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. ( )

03. ACPE. Accreditation Council for Pharmacy Education. ( )

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. ( )

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). ( )

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. ( )

07. CDC. United States Department of Health and Human Services, Centers for Disease Control and Prevention. ( )

08. Change of Ownership. A change of majority ownership or controlling interest of a drug outlet licensed or registered by the Board. ( )

09. CLIA-Waived Test. A test that is waived under the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988. ( )

10. Clinical Guidelines. Recommendations from a reputable organization that are evidence-based and intended to optimize patient care in specific clinical circumstances. ( )

11. CME. Continuing medical education. ( )

12. Collaborative Pharmacy Practice. A pharmacy practice whereby one (1) or more pharmacists or pharmacies 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. ( )

13. Collaborative Pharmacy Practice Agreement. A written agreement between one (1) or more pharmacists or pharmacies and one (1) or more prescribers that provides for collaborative pharmacy practice. ( )

14. Community Pharmacy. A community or other pharmacy that sells prescription drugs at retail and is open to the public for business. ( )

15. 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. ( )

16. **CPE**. Continuing pharmacy education. ( )

17. **CPE Monitor**. An NABP service that allows pharmacists to electronically keep track of CPE credits from ACPE-accredited providers. ( )

18. **DEA**. United States Drug Enforcement Administration. ( )

19. **Distributor**. A supplier of drugs manufactured, produced, or prepared by others to persons other than the ultimate consumer. ( )

20. **DME**. Durable medical equipment. ( )

21. **Drug Product Selection**. The act of selecting either a brand name drug product or its therapeutically equivalent generic. ( )

22. **Drug Product Substitution**. Dispensing a drug product other than prescribed. ( )

23. **DTM -- Drug Therapy Management**. Selecting, initiating, or modifying drug treatment pursuant to a collaborative pharmacy practice agreement or statewide protocol agreement. ( )

011. DEFINITIONS AND ABBREVIATIONS (E -- N).
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the following terms shall have the meanings set forth below: ( )

01. **Emergency Drugs**. Drugs necessary 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. ( )

02. **Executive Director**. The Idaho State Board of Pharmacy executive director created by Sections 54-1713 and 54-1714, Idaho Code. ( )

03. **FDA**. United States Food and Drug Administration. ( )

04. **Flavoring Agent**. An additive in food or drugs when used in accordance with the principles of good pharmacy practices and in the minimum quantity necessary to produce its intended effect. ( )

05. **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. ( )

06. **FPGEC**. Foreign Pharmacy Graduate Examination Committee. ( )

07. **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. ( )

08. HIPAA. Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191). ( )

09. 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. ( )

10. Institutional Pharmacy. A pharmacy located in an institutional facility. ( )

11. 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. ( )

12. Limited Service Outlet. Limited service outlets include, but are not limited to, sterile product pharmacies, remote dispensing pharmacies, facilities operating narcotic treatment programs, durable medical equipment outlets, prescriber drug outlets, outsourcing facilities, nuclear pharmacies, cognitive service pharmacies, correctional facilities, offsite ADSs for non-emergency dispensing, reverse distributors, and analytical or research laboratories. ( )

13. Maintenance Drug. A drug intended for the treatment of a health condition or disease that is persistent or otherwise expected to be long lasting in its effects. ( )

14. Medication Synchronization Program. An opt-in program provided by a pharmacy for aligning the refill dates of a patient's prescription drugs so that drugs that are refilled at the same frequency may be refilled concurrently. ( )

15. MPJE. Multistate Pharmacy Jurisprudence Exam. ( )

16. NABP. National Association of Boards of Pharmacy. ( )

17. NAPLEX. North American Pharmacists Licensure Examination. ( )

18. NDC. National Drug Code. ( )

012. DEFINITIONS AND ABBREVIATIONS (O -- Z).
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the following terms shall have the meanings set forth below: ( )

01. Parenteral Admixture. The preparation and labeling of sterile products intended for administration by injection. ( )

02. 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 also encompasses services provided by way of DTM under a collaborative practice agreement, statewide protocol agreement, pharmacotherapy, clinical pharmacy practice, pharmacist independent practice, and Medication Therapy Management. 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: ( )

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; ( )

b. Reviewing, analyzing, evaluating, formulating or providing a drug utilization plan; ( )

c. Monitoring and evaluating the patient's response to drug therapy, including safety and effectiveness; ( )

d. Performing a comprehensive drug review to identify, resolve, and prevent drug-related problems, including adverse drug events; ( )

e. Documenting the care delivered; ( )

f. Communicating essential information or referring the patient when necessary or appropriate; ( )

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; ( )

h. Conducting a drug therapy review consultation with the patient or caregiver; ( )

i. Preparing or providing information as part of a personal health record; ( )

j. Identifying processes to improve continuity of care and patient outcomes; ( )

k. Providing consultative drug-related intervention and referral services; ( )

l. Coordinating and integrating pharmaceutical care services within the broader health care management services being provided to the patient; ( )

m. Ordering and interpreting laboratory tests; and ( )

n. Other services as allowed by law. ( )

03. Pharmacy Operations. Activities related to and including the preparation, compounding, distributing, or dispensing of drugs or devices from a pharmacy. ( )

04. PDMP. Prescription Drug Monitoring Program. ( )

05. 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. ( )

06. Prescriber. An individual currently licensed, registered, or otherwise authorized to prescribe and administer drugs in the course of professional practice. ( )

07. 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. ( )

08. Readily Retrievable. Records are considered readily retrievable if they are able to be completely and legibly produced upon request within seventy-two (72) hours. ( )

09. 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. ( )

10. Restricted Drug Storage Area. The area of a drug outlet where prescription drugs are prepared, compounded, distributed, dispensed, or stored. ( )

11. Sample. A unit of a drug that is not intended to be sold and is intended to promote the sale of the drug. ( )

12. 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. ( )

13. Student Technician. A student who is enrolled in a high school or college supervised program, and who does not otherwise meet the requirements for registration as a technician-in-training or certified technician. ( )

14. Technician. Unless specifically differentiated, a term inclusive of pharmacy technician, certified 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. ( )

15. Telepharmacy. The use of telecommunications and information technologies in the practice of pharmacy to provide pharmaceutical care services to patients at a distance. ( )

16. 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). ( )

17. 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). ( )

18. USP. United States Pharmacopeia. ( )

19. USP-NF. United State Pharmacopeia-National Formulary. ( )

20. USP 795. The current edition of the United States Pharmacopeia-National Formulary, Chapter 795. ( )

21. USP 797. The current edition of the United States Pharmacopeia-National Formulary, Chapter 797. ( )

22. VAWD -- Verified Accredited Wholesale Distributor. An accreditation program for wholesale distributors offered through NABP. ( )

013. – 019. (RESERVED)

020. PRACTICE OF PHARMACY: GENERAL APPROACH.
To evaluate whether a specific act is within the scope of pharmacy practice in or into Idaho, a licensee or registrant of the Board must independently determine whether: ( )

01. Express Prohibition. The act is expressly prohibited by: ( )

a. The Idaho Pharmacy Act, Title 54, Chapter 17, Idaho Code; ( )

b. The Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code; ( )

c. The rules of the Idaho State Board of Pharmacy; or ( )

d. Any other applicable state or federal laws, rules or regulations. ( )

02. Education and Training. The act is consistent with licensee or registrant's education, training or practice experience. ( )

03. Standard of Care. Performance of the act is within the accepted standard of care that would be provided in a similar setting by a reasonable and prudent licensee or registrant with similar education, training and experience. ( )

021. WAIVERS OR VARIANCES.

01. Criteria. The board may grant or deny, in whole or in part, a waiver of, or variance from, specified rules if the granting of the waiver or variance is consistent with the Board's mandate to promote, preserve and protect public health, safety and welfare, and based on consideration of one (1) or both of the following: ( )

a. The application of a certain rule or rules is unreasonable and would impose an undue hardship or burden on the petitioner; or ( )

b. The waiver or variance requested would test an innovative practice or service delivery model. ( )

02. Content and Filing of a Waiver or Variance Petition. A written petition for waiver or variance should include at least the following: ( )

a. The name, address, and telephone number of the petitioner or petitioners; ( )

b. A specific reference to the rule or rules from which a waiver or variance is requested; ( )

c. A statement detailing the waiver or variance requested, including the precise scope and duration; and ( )

d. A description of how the waiver or variance, if granted, will afford substantially equal protection of public health, safety, and welfare intended by the particular rule for which the waiver or variance is requested. ( )

03. Invalid Requests. A waiver or variance request that is contrary to federal law or Idaho Code or that seeks to delay or cancel an administrative deadline will not be considered or granted by the Board. ( )

04. Time Period of Waiver or Variance. Waivers or variances may be granted on a permanent or temporary basis. Temporary waivers or variances have no automatic renewal, but may be renewed if the Board finds that sufficient grounds to allow the waiver or variance continue to exist. ( )

05. Cancellation or Modification of a Waiver or Variance. A waiver or variance granted by the Board may be canceled or modified by the Board at any time. ( )

022. BOARD INSPECTIONS AND INVESTIGATIONS.

01. Records Subject to Board Inspection. Records created, maintained, or retained by Board licensees or registrants in compliance with statutes or rules enforced by the Board must be made available for inspection upon request by Board inspectors or authorized agents. It is unlawful to refuse to permit or to obstruct a Board inspection. ( )

02. Inspections. Prior to the commencement of business, as applicable, and thereafter at regular intervals, upon presentation of appropriate identification, registrants and licensees must permit the Board or its compliance officers to enter and inspect the premises and to audit the records of each drug outlet for compliance with laws enforced by or under the Board's jurisdiction. ( )

03. Inspection Deficiencies. Deficiencies noted must be promptly remedied, and if requested, the Board office notified of corrective measures. If required, one (1) follow-up inspection may be performed by the Board at no cost. For additional follow-up inspections, the drug outlet will be charged actual travel and personnel costs incurred in the inspection and must pay within ninety (90) days of inspection. ( )

04. Inspection Reports. Inspection reports must be reviewed with the Board inspector and signed by an agent of the drug outlet upon completion of the exit interview. ( )

05. Investigations. Licensees or registrants must also fully cooperate with Board investigations conducted to confirm compliance with laws enforced by the Board, to gather information pertinent to a complaint received by the Board, or to enforce disciplinary actions. ( )

023. UNPROFESSIONAL CONDUCT.
The following acts or practices by a*ny licensee* or *registrant* are declared to be specifically, but not by way of limitation, unprofessional conduct and conduct contrary to the public interest. *( )*

01. Unethical Conduct. Conduct in the practice of pharmacy or in the operation of a pharmacy that may reduce the public confidence in the ability and integrity of the profession of pharmacy or endangers the public health, safety, and welfare. A violation of this section includes committing fraud, misrepresentation, negligence, concealment, or being involved in dishonest dealings, price fixing, or breaching the public trust with respect to the practice of pharmacy. ( )

02. Lack of Fitness. A lack of fitness for professional practice due to incompetency, personal habits, drug or alcohol dependence, physical or mental illness, or for any other cause that endangers public health, safety, or welfare. ( )

03. On-Duty Intoxication or Impairment. Intoxication, impairment, or consumption of alcohol or drugs while on duty, including break periods after which the individual is expected to return to work, or prior to reporting to work. ( )

04. Diversion of Drug Products and Devices. Supplying or diverting drugs, biologicals, and other medicines, substances, or devices legally sold in pharmacies that allows the circumvention of laws pertaining to the legal sale of these articles. ( )

05. Unlawful Possession or Use of Drugs. Possessing or using a controlled substance without a lawful prescription drug order. A failed drug test creates a rebuttable presumption of a violation of this rule. ( )

06. Prescription Drug Order Noncompliance. Failing to follow the instructions of the person writing, making, or ordering a prescription as to its refills, contents, or labeling except as provided in these rules. ( )

07. Failure to Confer. Failure to confer with the prescriber when necessary or appropriate or filling a prescription if necessary components of the prescription drug order are missing or questionable. ( )

08. Excessive Provision of Controlled Substances. Providing a clearly excessive amount of controlled substances. Evidentiary factors of a clearly excessive amount include, but are not limited to, the amount of controlled substances furnished and previous ordering patterns (including size and frequency of orders). ( )

09. Failure to Counsel or Offer Counseling. Failing to counsel or offer counseling, unless specifically exempted or refused. ( )

10. Substandard, Misbranded, Adulterated, or Expired Products. Manufacturing, compounding, delivering, dispensing, or permitting to be manufactured, compounded, delivered, or dispensed substandard, misbranded, or adulterated drugs or preparations or those made using secret formulas. Failing to remove expired drugs from stock. ( )

11. Prescriber Incentives. Allowing a commission or rebate to be paid, or personally paying a commission or rebate, to a person writing, making, or otherwise ordering a prescription. ( )

12. Exclusive Arrangements. Participation in a plan or agreement that compromises the quality or extent of professional services or limits access to provider facilities at the expense of public health or welfare. ( )

13. Failure to Report. Failing to report to the Board any violation of statutes or rules pertaining to the practice of pharmacy or any act that endangers the health, safety, or welfare of patients or the public. ( )

14. Failure to Follow Board Order. Failure to follow an order of the Board. ( )

15. Use of False Information. Knowingly using false information in connection with the prescribing, delivering, administering, or dispensing of a controlled substance or other drug product is prohibited. ( )

16. Standard of Care. Providing health care services which fail to meet the standard provided by other qualified licensees or registrants in the same or similar setting. ( )

17. Unnecessary Services or Products. Directly promoting or inducing for the provisions of health care services or products that are unnecessary or not medically indicated. ( )

024. – 999. (RESERVED)

IDAPA 27 – BOARD OF PHARMACY

27.01.03 – RULES GOVERNING PHARMACY PRACTICE

DOCKET NO. 27-0103-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 rules are generally adopted as originally proposed. Subsection 400.05 was updated to clarify that central records storage is acceptable for all pharmacy records if the pharmacy does so in compliance with federal 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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 418 through 434**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Alex Adams at (208) 334-2356.

DATED this 27th day of October, 2017.

Alex J. Adams, Pharm D, MPH
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 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: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Wednesday, October 25, 2017 – 9:00 a.m. (MDT)

Idaho State Capitol Building
Room WW53
700 West Jefferson Street
Boise, ID 83702

For those planning to attend the open public hearing, the Board will accept written and verbal comments. For all others not planning to attend the public hearing, written comments will be accepted by the Executive Director on or before close of business on October 24, 2017 as follows:

- Written comments received by October 20, 2017 will be included in the Board's distributed meeting material for consideration in advance of the hearing.
- Written comments received between October 21, 2017 and October 24, 2017 will be printed and provided to the Board at the open public hearing.

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

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

The scope of Chapter 27.01.03 is to establish the rules governing the practice of pharmacy. This chapter is comprised of current rules as follows: professional practice standards, drug outlet practice standards, filling and dispensing prescription drugs, recordkeeping and reporting requirements, and prescription drug monitoring program requirements. Changes made to the current rules include:

- Specific requirements related to fixtures, books, equipment, or staffing patterns that drug outlets must have are removed;
- The rules emphasize "what" needs to occur as a means to improve public safety, as opposed to "how" or "where" it occurs. As such, the offsite pharmacy services rule is broadened;
- The rules clarify which drug outlets must have a person-in-charge;
- Specific technology requirements, such as those related to ADSs, are removed;
- Emergency refill authorizations for non-controlled substances are specified; and
- The requirement that all employment changes must be reported by the PIC has been removed.

These rules will take effect in their entirety on July 1, 2018.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted in two separate open, public meetings on August 1, 2017 and August 30, 2017. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published under Docket No. 27-0101-1701 in the June 7, 2017 Idaho Administrative Bulletin, **Vol. 17-6, pages 54 through 56**, and in the August 2, 2017 Idaho Administrative Bulletin, **Vol. 17-8, pages 114 through 115**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams 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 25, 2017.

DATED this 30th day of August, 2017.

LSO Rules Analysis Memo

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

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0103-1701

IDAPA 27
TITLE 01
CHAPTER 03

27.01.03. – RULES GOVERNING PHARMACY PRACTICE

SUBCHAPTER A – STANDARD PROVISIONS
(Rules 000 through 099 – Standard Provisions)

000. LEGAL AUTHORITY.
This chapter is adopted under the legal authority of the Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code; the Idaho Pharmacy Act, the Idaho Wholesale Drug Distribution Act, and the Idaho Legend Drug Donation Act, Title 54, Chapter 17, Idaho Code; and specifically pursuant to Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, and 54-1763, Idaho Code. ( )

001. TITLE AND SCOPE.
In addition to the General Provisions set forth in "General Provisions," IDAPA 27.01.01, the following title and scope shall apply to these rules: ( )

01. Title. The title of this chapter is "Rules Governing Pharmacy Practice," IDAPA 27, Title 01, Chapter 03. ( )

02. Scope. The scope of this chapter includes, but is not limited to, provision for, and clarification of, the Board's assigned responsibility to: ( )

a. Regulate drug outlet practice standards; ( )

b. Regulate and control the filling and dispensing of prescription drugs; and ( )

c. Regulate drug outlet recordkeeping and reporting requirements. ( )

002. WRITTEN INTERPRETATIONS.
In accordance with Title 67, Chapter 52, Idaho Code, this agency may have written statements that pertain to the interpretation of, or to compliance with the rules of this chapter. Any such documents are available for public inspection and copying at cost at the Idaho Board of Pharmacy office. ( )

003. ADMINISTRATIVE PROCEEDINGS AND APPEALS.
Administrative proceedings and appeals are administered by the Board in accordance with the "Idaho Rules of Administrative Procedure of the Attorney General," IDAPA 04.11.01, Subchapter B -- Contested Cases, Rules 100 through 800. ( )

01. Place and Time for Filing. Documents in rulemakings or contested cases must be filed with the executive director of the Board at the Board office between the hours of 8 a.m. and 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

02. Manner of Filing. One (1) original of each document is sufficient for filing; however, the person or officer presiding over a particular rulemaking or contested case proceeding may require the filing of additional copies. A document may be filed with the Board by e-mail or fax if legible, complete, and received during the Board's office hours. The filing party is responsible for verifying with Board staff that an e-mail or fax was successfully and legibly received. ( )

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference into these rules. ( )

005. BOARD OFFICE INFORMATION.

01. Street Address. The office is located at 1199 Shoreline Lane, Suite 303, Boise, Idaho. ( )

02. Mailing Address. The mailing address is P.O. Box 83720, Boise, Idaho 83720-0067. ( )

03. Telephone Number. The telephone number is (208) 334-2356. ( )

04. Fax Number. The fax number is (208) 334-3536. ( )

05. Electronic Address. The website address is https://bop.idaho.gov. ( )

06. Office Hours. The office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

006. PUBLIC RECORDS ACT COMPLIANCE.
Board of Pharmacy records and filings are subject to compliance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. ( )

007. OFFICIAL BOARD JOURNAL.
The official journal of the Board is the electronic Idaho State Board of Pharmacy Newsletter. A link to recent versions of the newsletter is posted on the Board's website. Board licensees and registrants are presumed to have knowledge of the contents of the newsletter on the date of publication. The newsletter may be used in administrative hearings as proof of notification. ( )

008. – 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the definitions and abbreviations found at IDAPA 27.01.01.010 through 012 are applicable to these rules. ( )

011. – 099. (RESERVED)

SUBCHAPTER B – PROFESSIONAL PRACTICE STANDARDS
(Rules 100 through 199 – Professional Practice Standards)

100. PRESCRIBER PERFORMANCE OF PHARMACY FUNCTIONS.

01. Prescriber Roles. For the purposes of this chapter, any function that a pharmacist may perform may similarly be performed by an Idaho prescriber in the course of filling or dispensing prescription drugs. ( )

02. Prescriber Delegation. For the purposes of this chapter, any function that a pharmacist may delegate to a technician or pharmacist intern may similarly be delegated by an Idaho prescriber to an appropriate support personnel in accordance with the prescriber's practice act. ( )

101. DELEGATION OF PHARMACY FUNCTIONS.
A pharmacist may delegate to and allow performance by a technician or pharmacist intern only those functions performed in pharmacy operations that meet the following criteria: ( )

01. Supervision. The function is performed under a pharmacist's supervision; ( )

02. Education, Skill and Experience. The function is commensurate with the education, skill, and experience of the technician or pharmacist intern; and ( )

03. Professional Judgment Restriction. Any function that requires the use of a pharmacist's professional judgment may be performed by a pharmacist intern. ( )

102. – 199. (RESERVED)

SUBCHAPTER C – DRUG OUTLET PRACTICE STANDARDS
(Rules 200 through 299 - Drug Outlet Practice Standards)

200. PIC: RESPONSIBILITIES AND LIMITATIONS.

01. Drug Outlets that Must Designate a PIC. The following drug outlets must have a designated PIC by the date of opening and must not thereafter allow a vacancy of a designated PIC to continue for more than thirty (30) sequential days: ( )

a. Any drug outlet that dispenses drugs to patients in Idaho; ( )

b. Any central drug outlet; and ( )

c. Any outsourcing facility. ( )

02. PIC and Drug Outlet Responsibility. The PIC is responsible for the management of every part of the drug outlet and its regulated operations. The PIC and the drug outlet each have corresponding and individual responsibility for compliance with applicable state and federal law and these rules. ( )

03. PIC Oversight Limitations. A person may neither be designated nor function as the PIC for more than two (2) drug outlets concurrently. ( )

201. DRUG OUTLETS THAT DISPENSE PRESCRIPTION DRUGS: MINIMUM FACILITY STANDARDS.
A resident drug outlet that dispenses prescription drugs to patients in Idaho must meet the following minimum requirements: ( )

01. Security. A drug outlet must be constructed and equipped with adequate security to protect its equipment, records and supply of drugs, devices and other restricted sale items from unauthorized access, acquisition or use. An alarm or other comparable monitoring system is required for any non-institutional drug outlet that stocks controlled substances and is new or remodeled after July 1, 2018. ( )

02. Patient Privacy. All protected health information must be stored and maintained in accordance with HIPAA. In addition, a community pharmacy that is new or remodeled after March 21, 2012 must provide and maintain a patient consultation area that affords the patient auditory and visual privacy and is compliant with the Americans with Disabilities Act. ( )

03. Equipment. A drug outlet must be properly equipped to ensure the safe, clean, and sanitary condition necessary and appropriate for proper operation, the safe preparation of prescriptions, and to safeguard product integrity. ( )

04. Staffing. A drug outlet must be staffed sufficiently to allow for appropriate supervision, to otherwise operate safely and, if applicable, to remain open during the hours posted as open to the public for business. ( )

05. Controlled Substances Storage. Controlled substances must be stored in a securely locked, substantially constructed cabinet or safe. However, a pharmacy may disperse substances listed in Schedules II, III, IV and V, in whole or in part, throughout the stock of non-controlled substances if doing so would be likely to obstruct the theft or diversion of the controlled substances. ( )

06. Controlled Substances Disposal. Expired, excess or unwanted controlled substances that are owned by the drug outlet must be properly disposed of through the services of a DEA-registered reverse distributor or by another method permitted by federal law. ( )

07. Authorized Access to the Restricted Drug Storage Area. ( )

a. Access to the restricted drug storage area can occur only when a pharmacist or prescriber is on duty. ( )

b. Access must be limited to pharmacists, technicians and pharmacist interns, or in the case of a prescriber drug outlet, to prescribers and appropriate support personnel in accordance with the prescriber's practice act. A pharmacist or prescriber may, however, authorize an individual temporary access to the restricted drug storage area to perform a legitimate non-pharmacy function if the individual remains under the direct supervision of the pharmacist or prescriber. ( )

c. An institutional facility may also develop an emergency drug access protocol in which a non-pharmacist health professional may enter into the restricted drug storage area of an institutional facility that is otherwise closed, and pursuant to a valid prescription drug order, remove a sufficient quantity of non-controlled drugs necessary to meet the immediate needs of a patient. ( )

202. DRUG OUTLETS THAT DISPENSE PRESCRIPTION DRUGS: MINIMUM PRESCRIPTION FILLING REQUIREMENTS.
Unless exempted by these rules, each drug outlet that dispenses prescription drugs to patients in Idaho must meet the following minimum requirements: ( )

01. Valid Prescription Drug Order. Prescription drugs must only be dispensed pursuant to a valid prescription drug order as set forth in Subchapter D of these rules. ( )

02. Prospective Drug Review. Prospective drug review, as defined in Section 54-1705, Idaho Code, must be provided as set forth in Section 54-1739, Idaho Code. ( )

03. Labeling. Each drug must bear a complete and accurate label as set forth in Subchapter D of these rules. ( )

04. Verification of Dispensing Accuracy. Verification of dispensing accuracy must be performed to compare the drug stock selected to the drug prescribed. If not performed by a pharmacist or prescriber, an electronic verification system must be used that confirms the drug stock selected to fill the prescription is the same as indicated on the prescription label. A compounded drug may only be verified by a pharmacist or prescriber. ( )

05. Patient Counseling. Counseling, as defined in Section 54-1705, Idaho Code, must be provided as set forth in Section 54-1739, Idaho Code. ( )

203. OFFSITE PHARMACY SERVICES.
A drug outlet may provide offsite pharmacy services at one (1) or more locations. When the services being performed are related to prescription fulfillment or processing, the drug outlet must comply with the following: ( )

01. Policies and Procedures. The originating drug outlet must have written policies and procedures outlining the offsite pharmacy services to be provided by the central drug outlet, or the offsite pharmacist or technician, and the responsibilities and accountabilities of each party. ( )

02. Secure Electronic File. The parties share a secure common electronic file or utilize other secure technology, including a private, encrypted connection that allows access by the central drug outlet or offsite pharmacist or technician to information necessary to perform offsite pharmacy services. ( )

03. Exemption. A single prescription drug order may be shared by an originating drug outlet and a central drug outlet, or offsite pharmacist or technician. The filling, processing and delivery of a prescription drug order by one pharmacy for another pursuant to this section will not be construed as the filling of a transferred prescription or as a wholesale distribution. ( )

204. DRUG OUTLETS THAT DISPENSE DRUGS TO PATIENTS WITHOUT AN ONSITE PHARMACIST OR PRESCRIBER.
In addition to all other preceding rules of this subchapter, a drug outlet that dispenses drugs to patients in Idaho that does not have a pharmacist or prescriber onsite to perform or supervise pharmacy operations must comply with the following requirements: ( )

01. Security and Access. ( )

a. The drug outlet must maintain video surveillance with an adequate number of views of the full facility and retain a high quality recording for a minimum of ninety (90) days. ( )

b. Proper identification controls of individuals accessing the restricted drug storage area must be utilized and access must be limited, authorized, and regularly monitored. ( )

02. Staffing Limitations. The ratio of pharmacists to support personnel may not exceed one (1) pharmacist for every six (6) technicians and pharmacist interns in total across all practice sites. ( )

03. Technology. The video and audio communication system used to counsel and interact with each

patient or patient's caregiver, must be clear, secure, and HIPAA-compliant. ( )

04. Controlled Substances Inventories. ( )

a. A perpetual inventory must be kept for all Schedule II controlled substances; and ( )

b. If a perpetual inventory is not kept for all Schedule III through V substances, the pharmacist or prescriber must inventory and audit at least three (3) random controlled substances quarterly. ( )

05. Self-Inspection. A pharmacist or prescriber must complete and retain a monthly in-person self-inspection of the drug outlet using a form designated by the Board. ( )

06. Emergency Situations. ( )

a. A pharmacist or prescriber must be capable of being on site at the drug outlet within twelve (12) hours if an emergency arises. ( )

b. The drug outlet must be, or remain, closed to the public if any component of the surveillance or video and audio communication system is malfunctioning, until system corrections or repairs are completed. ( )

07. Exemption for Self-Service Systems. A self-service ADS that is operating as a drug outlet is exempt from the video surveillance requirement and the self-inspection requirement of this rule. In addition, if counseling is provided by an onsite prescriber or pharmacist, a self-service ADS is exempt from the video and audio communication system requirements of this rule. ( )

08. Exemption for Veterinarians. Veterinarians practicing in accordance with their Idaho practice act are exempt from this rule. ( )

205. DRUGS STORED OUTSIDE OF A DRUG OUTLET FOR RETRIEVAL BY A LICENSED HEALTH PROFESSIONAL.
Drugs may be stored in an alternative designated area outside the drug outlet, including, but not limited to, floor stock, in an emergency cabinet, in an emergency kit, or as emergency outpatient drug delivery from an emergency room at a registered institutional facility, provided the following conditions are met: ( )

01. Supervising Drug Outlet. Drugs stored in such a manner must remain under the control of, and be routinely monitored by, the supervising drug outlet. ( )

02. Policies and Procedures. The supervising drug outlet must develop and implement policies and procedures regarding authorized access to drugs stored in the alternative designated area, documentation of drugs used, drug returns and wastage, and regular inventory procedures. ( )

03. Secure Storage. The area is appropriately equipped to ensure security and protection from diversion or tampering. ( )

04. Controlled Substances. Controlled substances may only be stored in an alternative designated area as permitted by, and in accordance with, federal law. ( )

05. Stocking and Replenishing. Stocking or replenishing drugs in an alternative designated area may be performed by a pharmacist or prescriber, or by appropriate support personnel using either an electronic verification system or a two (2) person checking system. ( )

206. – 299. (RESERVED)

SUBCHAPTER D – FILLING AND DISPENSING PRESCRIPTION DRUGS
(Rules 300 through 399 - Filling and Dispensing Prescription Drugs)

300. PRESCRIPTION DRUG ORDER: VALIDITY.
Prior to filling or dispensing a prescription drug order, a pharmacist must verify its validity. ( )

01. Invalid Prescription Drug Orders. A prescription drug order is invalid if not issued: ( )

a. In good faith; ( )

b. For a legitimate medical purpose; ( )

c. By a licensed prescriber; ( )

d. Within the course and scope of the prescriber's professional practice and prescriptive authority; ( )

e. Pursuant to a valid prescriber-patient relationship, unless statutorily exempted; or ( )

f. In the form and including the elements specified in this Subchapter D. ( )

02. Antedating or Postdating. A prescription drug order is invalid if antedated or postdated. ( )

03. Tampering. A prescription drug order is invalid if, at the time of presentation, it shows evidence of alteration, erasure, or addition by any person other than the person who wrote it. ( )

04. Prescriber Self-Use. A prescription drug order written for a controlled substance is invalid if written for the prescriber's own use. ( )

05. Family Members. A prescription drug order written for a prescriber's family member is invalid if inconsistent with the scope of practice and prescriptive authority of the prescriber's profession. ( )

06. Expiration. A prescription drug order is invalid after its expiration date as follows: ( )

a. A prescription drug order for a Schedule II controlled substance must not be filled or dispensed more than ninety (90) days after its date of issue. ( )

b. A prescription drug order for a controlled substance listed in Schedules III, IV or V must not be filled or refilled more than six (6) months after its date of issue. ( )

c. A prescription drug order for a non-controlled drug must not be filled or refilled more than fifteen (15) months after its date of issue, unless if extended in accordance with these rules. ( )

07. Prescriber Change of Status. A prescription drug order is invalid after ninety (90) days from the date the pharmacist learns of a change in status that precludes a continued prescriber-patient relationship. ( )

301. PRESCRIPTION DRUG ORDER: SCHEDULE II DRUG LIMITATIONS

01. Faxed and Verbal Prescriptions. A Schedule II prescription must not be dispensed pursuant to a faxed or verbal prescription drug order, except as permitted by federal law. ( )

02. Multiple Prescription Drug Orders. A prescriber may issue and a pharmacy may fill multiple prescription drug orders, written on and dated with the same date, that allow the patient to receive up to a ninety (90)-day supply of a Schedule II controlled substance in accordance with federal law. ( )

302. PRESCRIPTION DRUG ORDER: MINIMUM REQUIREMENTS.
A prescription drug order must comply with applicable requirements of federal law and, except as differentiation is permitted for an institutional drug order, must include at least the following: ( )

01. Patient's Name. The patient's or authorized entity's name and: ( )

a. If for a controlled substance, the patient's full name and address; and ( )

b. If for an animal, the species. ( )

02. Date. The date issued. ( )

03. Drug Information. The drug name, strength, quantity and, if for a controlled substance, the dosage form. ( )

04. Directions. The directions for use. ( )

05. Prescriber Information. The name and, if for a controlled substance, the address and DEA registration number of the prescriber. ( )

06. Signature. If paper, the pre-printed, stamped or hand-printed name and written signature of the prescriber or, if statutorily allowed, the prescriber's agent's signature and, if electronic, the prescriber's electronic signature. ( )

07. Institutional Drug Order Exemptions. An institutional drug order may exempt the patient's address, the dosage form, quantity, prescriber's address, and prescriber's DEA registration number. ( )

303. FILLING PRESCRIPTION DRUG ORDERS: PRACTICE LIMITATIONS.

01. Drug Product Selection. Drug product selection is allowed only between therapeutic equivalent drugs. If a prescriber orders by any means that a brand name drug must be dispensed, then no drug product selection is permitted. ( )

02. Partial Filling. A prescription drug order may be partially filled within the limits of federal law. The total quantity dispensed in partial fillings must not exceed the total quantity prescribed. ( )

03. Refill Authorization. A prescription drug order may be refilled when permitted by state and federal law and only as specifically authorized by the prescriber, except as follows: ( )

a. A pharmacist acting in good faith and exercising reasonable care may dispense or refill a prescription drug that is not a controlled substance up to the total amount authorized by the prescriber including refills. ( )

b. A pharmacist may refill a prescription for a non-controlled drug one (1) time in a six (6)-month period when the prescriber is not available for authorization. In such cases, a pharmacist may dispense a refill up to the quantity on the most recent fill or a thirty (30)-day supply, whichever is less. ( )

304. FILLING PRESCRIPTION DRUG ORDERS: ADAPTATION.
Upon patient consent, a pharmacist acting in good faith and exercising reasonable care may adapt drugs as specified in this rule, provided that the drug is not for a controlled substance, compounded drug, or biological product, and provided that the prescriber has not indicated by any means necessary that adaptation is not permitted. ( )

01. Change Quantity. A pharmacist may change the quantity of medication prescribed if: ( )

a. The prescribed quantity or package size is not commercially available; or ( )

b. The change in quantity is related to a change in dosage form. ( )

02. Change Dosage Form. A pharmacist may change the dosage form of the prescription if it is in the best interest of patient care, so long as the prescriber's directions are also modified to equate to an equivalent amount of drug dispensed as prescribed. ( )

03. Complete Missing Information. A pharmacist may complete missing information on a prescription if there is sufficient evidence to support the change. ( )

04. Medication Synchronization. A pharmacist may extend a maintenance drug for the limited quantity necessary to coordinate a patient's refills in a medication synchronization program. ( )

05. Documentation. A pharmacist who adapts a prescription in accordance with these rules must document the adaptation in the patient's record. ( )

305. FILLING PRESCRIPTION DRUG ORDERS: DRUG PRODUCT SUBSTITUTION.
Drug product substitutions are allowed only as follows: ( )

01. Hospital. Pursuant to a formulary or drug list prepared by the pharmacy and therapeutics committee of a hospital; ( )

02. Skilled Nursing Facility. At the direction of the quality assessment and assurance committee of a skilled nursing facility; ( )

03. Drug Shortage. Upon a drug shortage, a pharmacist may exercise professional judgment, without contacting the prescriber, and may substitute an alternative dose of a prescribed drug, so long as the prescriber's directions are also modified, to equate to an equivalent amount of drug dispensed as prescribed; or ( )

04. Biosimilars. A pharmacist may substitute an interchangeable biosimilar product for a prescribed biological product if: ( )

a. The biosimilar has been determined by the FDA to be interchangeable and published in the Purple Book; ( )

b. The prescriber does not indicate by any means that the prescribed biological product must be dispensed; and ( )

c. The name of the drug and the manufacturer or the NDC number is documented in the patient medical record. ( )

306. FILLING PRESCRIPTION DRUG ORDERS: TRANSFERS.

01. Communicating Prescription Drug Order Transfers. A prescription drug order may be transferred within the limits of federal law. A controlled substance listed in Schedules III, IV or V may be transferred only from the drug outlet where it was originally filled and never from the drug outlet that received the transfer. ( )

02. Pharmacies Using Common Electronic Files. Drug outlets using a common electronic file are not required to transfer prescription drug order information for dispensing purposes between or among other drug outlets sharing the common electronic file. ( )

307. LABELING: STANDARD PRESCRIPTION DRUG.
Unless otherwise directed by these rules, a prescription drug must be dispensed in an appropriate container that bears the following information: ( )

01. Dispenser Information. The name, address, and telephone number of the dispenser (person or business). ( )

02. Serial Number. The serial number. ( )

03. Date. The date the prescription is filled. ( )

04. Prescriber. The name of the prescriber. ( )

05. Name. ( )

a. If a person, the name of the patient or other person authorized to possess a legend drug in accordance with Idaho Code; ( )

b. If an animal, the name and species of the patient; or ( )

c. If a facility or other entity is authorized to possess a legend drug in accordance with Idaho Code, the name of the facility or entity. ( )

06. Drug Name and Strength. Unless otherwise directed by the prescriber, the name and strength of each drug included (the generic name and its manufacturer's name or the brand name). ( )

07. Quantity. The quantity of item dispensed. ( )

08. Directions. The directions for use. ( )

09. Cautionary Information. Cautionary information as necessary or deemed appropriate for proper use and patient safety. ( )

10. Expiration. An expiration date that is either: ( )

a. The lesser of: ( )

i. One (1) year from the date of dispensing; ( )

ii. The manufacturer's original expiration date; ( )

iii. The appropriate expiration date for a reconstituted suspension or beyond use date for a compounded product; or ( )

iv. A shorter period if warranted. ( )

b. If dispensed in the original, unopened manufacturer packaging, the manufacturer's original expiration date. ( )

11. Refills. The number of refills remaining, if any, or the last date through which the prescription is refillable. ( )

12. Warning. A warning sufficient to convey that state or federal law, or both, prohibits the transfer of this drug to any person other than the patient for whom it was prescribed, except when dispensing to an animal, when a warning sufficient to convey "for veterinary use only" may be utilized. ( )

13. Identification. The initials or other unique identifier of the dispensing pharmacist or dispensing prescriber. ( )

308. LABELING: INSTITUTIONAL FACILITY DRUGS.
Except if dispensed in unit dose packaging, a drug dispensed for patient use while in a hospital must be dispensed in an appropriate container that bears at least the following information: ( )

01. Date. The date filled; ( )

02. Patient. The name of the patient; ( )

03. Drug. The name and strength of the drug; ( )

04. **Quantity**. The quantity of item dispensed; ( )

05. **Directions**. The directions for use, including the route of administration; ( )

06. **Caution**. Cautionary information as necessary or deemed appropriate for proper use and patient safety; ( )

07. **Expiration Date**. The expiration or beyond use date, if appropriate; and ( )

08. **Pharmacist**. The initials or other unique identifier of the dispensing pharmacist. ( )

309. LABELING: PARENTERAL ADMIXTURE.
If one (1) or more drugs are added to a parenteral admixture, the admixture's container must include a distinctive, supplementary label with at least the following information: ( )

01. **Ingredient Information**. The name, amount, strength and, if applicable, the concentration of the drug additive and the base solution or diluent; ( )

02. **Date and Time**. The date and time of the addition, or alternatively, the beyond use date; ( )

03. **Identification**. The initials or other unique identifier of the pharmacist or preparing prescriber responsible for its accuracy; ( )

04. **Prescribed Administration Regimen**. The rate or appropriate route of administration or both, as applicable; and ( )

05. **Special Instructions**. Any special handling, storage, or device-specific instructions. ( )

310. LABELING: PREPACKAGED PRODUCT.
The containers of prepackaged drugs prepared for ADS systems or other authorized uses must include a label with at least the following information: ( )

01. **Drug Name and Strength**. The name and strength of the drug; ( )

02. **Expiration Date**. An expiration date that is the lesser of: ( )

a. The manufacturer's original expiration date; ( )

b. One (1) year from the date the drug is prepackaged; or ( )

c. A shorter period if warranted (A prepackaged drug returned unopened from an institutional facility and again prepackaged must be labeled with the expiration date used for the initial prepackaging.); ( )

03. **Conditional Information**. If not maintained in a separate record, the manufacturer's name and lot number and the identity of the pharmacist or provider responsible for the prepackaging. ( )

311. DISPENSING CONTROLLED SUBSTANCES: POSITIVE IDENTIFICATION REQUIRED.
A potential recipient of a controlled substance must first be positively identified or the controlled substance must not be dispensed. ( )

01. **Positive Identification Presumed**. Positive identification is presumed and presentation of identification is not required if dispensing directly to the patient and if: ( )

a. The controlled substance will be paid for, in whole or in part, by an insurer; ( )

b. The patient is being treated at an institutional facility or is housed in a correctional facility; or ( )

c. The filled prescription is delivered to the patient or patient's provider. ( )

02. Personal Identification. Presentation of identification is also not required if the individual receiving the controlled substance is personally and positively known by a drug outlet staff member who is present and identifies the individual and the personal identification is documented by recording: ( )

a. The recipient's name (if other than the patient); ( )

b. A notation indicating that the recipient was known to the staff member; and ( )

c. The identity of the staff member making the personal identification. ( )

03. Acceptable Identification. A valid government-issued identification must include an unaltered photograph and signature to be acceptable. ( )

04. Identification Documentation. Documentation of the recipient's identification must be permanently linked to the record of the dispensed controlled substance and include: ( )

a. A copy of the identification presented; or ( )

b. A record that includes: ( )

i. The recipient's name; ( )

ii. A notation of the type of identification presented; ( )

iii. The government entity that issued the identification; and ( )

iv. The unique identification number. ( )

312. DISPENSING CONTROLLED SUBSTANCES: NON-PRESCRIPTION DISPENSING LIMITATIONS.
Limited quantities of a Schedule V non-prescription controlled substance may be dispensed to a retail purchaser as permitted by federal law. ( )

313. PRESCRIPTION DELIVERY: RESTRICTIONS.

01. Acceptable Delivery. A drug outlet that dispenses drugs to patients in Idaho may deliver filled prescriptions to the following, as long as appropriate measures are taken to ensure product integrity: ( )

a. To the patient or the patient's residence, the institutional facility in which the patient is convalescing, the correctional facility in which a patient is housed; ( )

b. To the patient's licensed or registered healthcare provider, as follows: ( )

i. If the drug is not a controlled substance; or ( )

ii. If the drug is a controlled substance that is intended for direct administration by the prescriber or prescriber's delegate. ( )

c. To another licensed drug outlet. ( )

02. Pick-up or Return by Authorized Personnel. Filled prescriptions may be picked up for or returned from delivery by authorized personnel when the drug outlet is closed for business if the prescriptions are placed in a secured delivery area outside of the restricted drug storage area that is equipped with adequate security, including an alarm or comparable monitoring system, to prevent unauthorized entry, theft and diversion under

policies and procedures developed by the PIC. ( )

314. DESTRUCTION OR RETURN OF DRUGS OR DEVICES: RESTRICTIONS.
A drug outlet registered with the DEA as a collector may collect controlled and non-controlled drugs for destruction in accordance with applicable federal law. Otherwise a dispensed drug or prescription device must only be accepted for return as follows: ( )

01. Error. Those that were dispensed in a manner inconsistent with the prescriber's instructions may be returned for quarantine and destruction purposes only. ( )

02. Did Not Reach Patient. Non-controlled drugs that have been maintained in the custody and control of the institutional facility, dispensing pharmacy, or their related clinical facilities may be returned if product integrity can be assured. Controlled substances may only be returned from a hospital daily delivery system under which a pharmacy dispenses no more than a twenty-four (24) hour supply for a drug order, or up to a seventy-two (72) hour supply for a drug order if warranted for good patient care. ( )

03. Donation. Those that qualify for return under the provisions of the Idaho Legend Drug Donation Act as specified in Section 54-1762, Idaho Code. ( )

315. REPACKAGING DRUG PREVIOUSLY DISPENSED.
A drug outlet may repackage a drug previously dispensed to a patient, pursuant to the patient or the patient's agent's request, if: ( )

01. Pharmacist Verification. The repackaging pharmacist verifies the identity of the previously dispensed drugs as matching the label on the container that the drugs were initially dispensed within. ( )

02. Intermingled Drugs. The drugs are never intermingled with the repackaging pharmacy's regular stock. ( )

03. Labeling. The repackaging pharmacy affixes to the container of the repackaged drug a label that complies with the standard labeling rule and includes: ( )

a. The original dispensed prescription's serial number; ( )

b. The name, address, and phone number of the original dispensing pharmacy; and ( )

c. A statement that indicates that the drug has been repackaged, such as the words "repackaged by" followed by the name of the repackaging pharmacy. ( )

316. – 399. (RESERVED).

SUBCHAPTER E – DRUG OUTLET RECORDKEEPING AND REPORTING REQUIREMENTS
(Rules 400 through 499 - Drug Outlet Recordkeeping and Reporting Requirements)

400. RECORDKEEPING: MAINTENANCE AND INVENTORY REQUIREMENTS.

01. Records Maintenance and Retention Requirement. Unless an alternative standard is stated for a specified record type, form, or format, records required to evidence compliance with statutes or rules enforced by the Board must be maintained and retained in a readily retrievable form and location for at least three (3) years from the date of the transaction. ( )

02. Prescription Retention. A prescription drug order must be retained in a readily retrievable manner by each drug outlet and maintained as follows: ( )

a. Schedule II Prescriptions. Paper prescription drug orders for Schedule II controlled substances must be maintained at the registered location in a separate prescription file. ( )

b. Schedule III through V Prescriptions. Paper prescription drug orders for Schedules III, IV and V controlled substances must be maintained at the registered location either in a separate prescription file for Schedules III, IV and V controlled substances only or in a readily retrievable manner from other prescription records as required by federal law. ( )

c. Electronic Prescriptions. Electronic prescription drug orders for controlled substances must be maintained in a system that meets the requirements of federal law. The records may be maintained at another location if readily retrievable at the registered location. The electronic application must be capable of printing or otherwise converting the records into a readily understandable format at the registered location and must allow the records to be sortable by prescriber name, patient name, drug dispensed, and date filled. ( )

03. Inventory Records. Each drug outlet must maintain a current, complete and accurate record of each controlled substance manufactured, imported, received, ordered, sold, delivered, exported, dispensed or otherwise disposed of by the registrant. Drug outlets must maintain inventories and records in accordance with federal law. An inventory must be conducted as follows: ( )

a. Annual Inventory of Stocks of Controlled Substances. Each registrant must conduct an inventory of controlled substances on hand annually at each registered location no later than seven (7) days after the date of the most recent inventory in a form and manner that satisfies the inventory requirements of federal law. A separate controlled substances inventory must be taken and retained at each DEA-registered location. ( )

b. Inventory on PIC Change. A complete controlled substance inventory must be conducted by the incoming PIC or his delegate on or by the first day of employment of the incoming PIC. ( )

c. Inventory on Addition to Schedule of Controlled Substances. On the effective date of an addition of a substance to a schedule of controlled substances, each registrant that possesses that substance must take an inventory of the substance on hand, and thereafter, include the substance in each inventory. ( )

d. Drugs Stored Outside a Drug Outlet. In addition to the annual inventory requirements, drugs stored outside a drug outlet in accordance with these rules must be regularly inventoried and inspected to ensure that they are properly stored, secured, and accounted for. ( )

e. Closing of Pharmacy. A closing inventory must be conducted and retained. ( )

04. Rebuttal Presumption of Violation. Evidence of an amount of a controlled substance that differs from the amount reflected on a record or inventory required by state or federal law creates a rebuttable presumption that the registrant has failed to keep records or maintain inventories in conformance with the recordkeeping and inventory requirements of state and federal law. ( )

05. Central Records Storage. *R*ecords may be retained at a central location *in compliance with* federal law. *( )*

06. Electronic Records Storage. Any record required to be kept under this section may be electronically stored and maintained if they remain legible and are in a readily retrievable format, and if federal law does not require them to be kept in a hard copy format. ( )

401. RECORDKEEPING: ELECTRONIC SYSTEM FOR PATIENT MEDICATION RECORDS.
A drug outlet that is new or remodeled after the effective date of this rule must use an electronic recordkeeping system to establish and store patient medication records and prescription drug order, refill, transfer information, and other information necessary to provide safe and appropriate patient care. ( )

01. Real-time Online Retrieval of Information. The electronic recordkeeping system must be capable of real-time, online retrieval of information stored therein for a minimum of fifteen (15) months from the date of entry. ( )

02. Immediately Retrievable Refill Data. The electronic recordkeeping system must have

functionality that allows refill data to be immediately retrievable and produced upon request; for example, a refill-by-refill audit trail for a specified strength and dosage form of a drug. ( )

03. Audit Trail Documentation. The electronic recordkeeping system must also have audit trail functionality that documents for each prescription drug order the identity of each individual involved at each step of its processing, filling, and dispensing or, alternatively, the identity of the pharmacist or prescriber responsible for the accuracy of these processes. Systems that automatically generate user identification without requiring an entry by the responsible individual are prohibited. Drug outlets that utilize offsite pharmacy services for product fulfillment or processing must track the identity and location of each individual involved in each step of the offsite pharmacy services. ( )

04. System Security. The electronic recordkeeping system must include security features to protect the confidentiality and integrity of patient records including: ( )

a. Safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription drug order information and patient medication records; and ( )

b. Functionality that documents any alteration of prescription drug order information after a prescription drug order is dispensed, including the identification of the individual responsible for the alteration. ( )

05. System Downtime, Backup and Recovery. The pharmacy must have policies and procedures in place for system downtime, backup and recovery. ( )

06. Exemption. Drug outlets are exempt from this section if they fill on average fewer than twenty (20) prescriptions per business day, and paper records must be maintained. ( )

402. REPORTING REQUIREMENTS.

01. PIC Change. Both an outgoing and incoming PIC must report to the Board a change in a PIC designation within ten (10) days of the change. ( )

02. Theft or Loss of Controlled Substances. A registrant must report to the Board on the same day reported to the DEA a theft or loss of a controlled substance that includes the information required by federal law. ( )

03. Individual Information Changes. Changes in employment or changes to information provided on or with the initial or renewal application must be reported to the Board within ten (10) days of the change. ( )

04. Reporting Adulteration or Misappropriation. A licensee or registrant must report to the Board any adulteration or misappropriation of a controlled drug in accordance with Section 37-117A. Idaho Code. ( )

403. – 499. (RESERVED)

SUBCHAPTER F – PRESCRIPTION DRUG MONITORING PROGRAM REQUIREMENTS
(Rules 500 through 999 – Prescription Drug Monitoring Program Requirements)

500. CONTROLLED SUBSTANCES: PDMP.
Specified data on controlled substances must be reported by the end of the next business day by all drug outlets that dispense controlled substances in or into Idaho and prescribers that dispense controlled substances to humans. Data on controlled substance prescription drug samples does not need to be reported. ( )

01. Online Access to PDMP. Online access to the Board's PDMP is limited to licensed prescribers and pharmacists, or their delegates, for treatment purposes. To obtain online access, a prescriber or pharmacist, or their delegate must complete and submit a registration application and agree to adhere to the access restrictions and limitations established by law. ( )

02. Use Outside Scope of Practice Prohibited. Information obtained from the PDMP must not be used for purposes outside the prescriber's or pharmacist's scope of professional practice. A delegate may not access the PDMP outside of their supervisor's scope of professional practice. ( )

03. Profile Requests. Authorized persons without online access may obtain a profile by completing a Board form and submitting it to the Board office with proof of identification and other credentials required to confirm the requestor's authorized status pursuant to Section 37-2726, Idaho Code. ( )

04. Suspension, Revocation, or Restriction of PDMP Access. Violation of this rule provides grounds for suspension, revocation, or restriction of the prescriber's, pharmacist's, or delegate's authorization for online access to the PDMP. ( )

501. – 999. (RESERVED)

IDAPA 27 – BOARD OF PHARMACY

27.01.04 – RULES GOVERNING PHARMACIST PRESCRIPTIVE AUTHORITY

DOCKET NO. 27-0104-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 rules were strengthened to ensure appropriate safeguards are in place. Specifically, the Board added provisions to narrow the prescribing under Sections 021, 027, 028, and Subsection 024.01, of these rules. In addition, Subsection 020.03.e., of these rules, was added to indicate the Board intends to make template protocols available for certain drugs and drug categories.

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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 435 through 440**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Alex Adams at (208) 334-2356.

DATED this 27th day of October, 2017.

Alex J. Adams, Pharm D, MPH
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: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Wednesday, October 25, 2017 – 9:00 a.m. (MDT)

Idaho State Capitol Building
Room WW53
700 West Jefferson Street
Boise, ID 83702

For those planning to attend the open public hearing, the Board will accept written and verbal comments. For all others not planning to attend the public hearing, written comments will be accepted by the Executive Director on or before close of business on October 24, 2017 as follows:

- Written comments received by October 20, 2017 will be included in the Board's distributed meeting material for consideration in advance of the hearing.
- Written comments received between October 21, 2017 and October 24, 2017 will be printed and provided to the Board at the open public hearing.

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

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

The scope of Chapter 27.01.04 is to specify which products pharmacists may prescribe. This chapter implements House Bill 191, which passed in the 2017 Idaho Legislature. House Bill 191 amended Section 54-1704, Idaho Code, and provided the Board of Pharmacy with rulemaking authority to designate drugs, drug categories, and devices that pharmacists may prescribe, provided certain conditions are met. In addition, existing rules related to collaborative pharmacy practice and statewide protocol agreements are organized into this chapter.

These rules will take effect in their entirety on July 1, 2018.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted in two separate open, public meetings on August 1, 2017 and August 30, 2017. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published under Docket No. 27-0101-1701 in the June 7, 2017 Idaho Administrative Bulletin, **Vol. 17-6, pages 54 through 56**, and in the August 2, 2017 Idaho Administrative Bulletin, **Vol. 17-8, pages 114 through 115**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams 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 25, 2017.

DATED this 30th day of August, 2017.

LSO Rules Analysis Memo

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

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0104-1701

IDAPA 27
TITLE 01
CHAPTER 04

27.01.04. – RULES GOVERNING PHARMACIST PRESCRIPTIVE AUTHORITY

000. LEGAL AUTHORITY.
This chapter is adopted under the legal authority of the Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code; the Idaho Pharmacy Act, the Idaho Wholesale Drug Distribution Act, and the Idaho Legend Drug Donation Act, Title 54, Chapter 17, Idaho Code; and specifically pursuant to Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, and 54-1763, Idaho Code. ( )

001. TITLE AND SCOPE.
In addition to the General Provisions set forth in "General Provisions," IDAPA 27.01.01, the following title and scope shall apply to these rules: ( )

01. **Title**. The title of this chapter is "Rules Governing Pharmacist Prescriptive Authority," IDAPA 27, Title 01, Chapter 04. ( )

02. **Scope**. The scope of this chapter includes, but is not limited to, provision for, and clarification of, the Board's assigned responsibility to determine which drugs or devices pharmacists can prescribe independently, and further establish criteria for collaborative pharmacy practice and statewide protocol agreements. ( )

002. WRITTEN INTERPRETATIONS.
In accordance with Title 67, Chapter 52, Idaho Code, this agency may have written statements that pertain to the

interpretation of, or to compliance with the rules of this chapter. Any such documents are available for public inspection and copying at cost at the Idaho Board of Pharmacy office. ( )

003. ADMINISTRATIVE PROCEEDINGS AND APPEALS.
Administrative proceedings and appeals are administered by the Board in accordance with the "Idaho Rules of Administrative Procedure of the Attorney General," IDAPA 04.11.01, Subchapter B -- Contested Cases, Rules 100 through 800. ( )

01. Place and Time for Filing. Documents in rulemakings or contested cases must be filed with the executive director of the Board at the Board office between the hours of 8 a.m. and 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

02. Manner of Filing. One (1) original of each document is sufficient for filing; however, the person or officer presiding over a particular rulemaking or contested case proceeding may require the filing of additional copies. A document may be filed with the Board by e-mail or fax if legible, complete, and received during the Board's office hours. The filing party is responsible for verifying with Board staff that an e-mail or fax was successfully and legibly received. ( )

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference into these rules. ( )

005. BOARD OFFICE INFORMATION.

01. Street Address. The office is located at 1199 Shoreline Lane, Suite 303, Boise, Idaho. ( )

02. Mailing Address. The mailing address is P.O. Box 83720, Boise, Idaho 83720-0067. ( )

03. Telephone Number. The telephone number is (208) 334-2356. ( )

04. Fax Number. The fax number is (208) 334-3536. ( )

05. Electronic Address. The website address is https://bop.idaho.gov. ( )

06. Office Hours. The office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

006. PUBLIC RECORDS ACT COMPLIANCE.
Board of Pharmacy records and filings are subject to compliance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. ( )

007. OFFICIAL BOARD JOURNAL.
The official journal of the Board is the electronic Idaho State Board of Pharmacy Newsletter. A link to recent versions of the newsletter is posted on the Board's website. Board licensees and registrants are presumed to have knowledge of the contents of the newsletter on the date of publication. The newsletter may be used in administrative hearings as proof of notification. ( )

008. – 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the definitions and abbreviations found at IDAPA 27.01.01.010 through 012 are applicable to these rules. ( )

011. – 019. (RESERVED)

020. PHARMACIST PRESCRIBING: GENERAL REQUIREMENTS.
In addition to all nonprescription drugs and devices and the statutorily authorized drug products and categories set forth in Section 54-1704, Idaho Code, a pharmacist acting in good faith and exercising reasonable care may

independently prescribe drugs, drug categories and devices as set forth in this chapter provided the following general requirements are met: ( )

01. Education. The pharmacist may only prescribe drugs or devices for conditions for which the pharmacist is educationally prepared and for which competence has been achieved and maintained. ( )

02. Patient-Prescriber Relationship. The pharmacist may only issue a prescription for a legitimate medical purpose arising from a patient-prescriber relationship as defined in Section 54-1733, Idaho Code. ( )

03. Patient Assessment. The pharmacist must obtain adequate information about the patient's health status to make appropriate decisions based on *the applicable standard of care*. *( )*

a. At a minimum, for each drug or drug category the pharmacist intends to prescribe, the pharmacist must maintain a patient assessment protocol based on current clinical guidelines, when available, or evidence-based research findings that specifies the following: ( )

b. Patient inclusion and exclusion criteria; and ( )

c. Explicit medical referral criteria. ( )

d. The pharmacist must revise the patient assessment protocol when necessary to ensure continued compliance with clinical guidelines or evidence-based research findings. The pharmacist's patient assessment protocol, and any related forms, must be made available to the Board upon request. ( )

e. *Any patient assessment protocol for a drug or drug category that is made available by the Board satisfies Paragraphs a. through c. of this subsection.* *( )*

04. Collaboration with Other Health Care Professionals. The pharmacist must recognize the limits of the pharmacist's own knowledge and experience and consult with and refer to other health care professionals as appropriate. ( )

05. Follow-Up Care Plan. The pharmacist must develop and implement an appropriate follow-up care plan, including any monitoring parameters, in accordance with clinical guidelines. ( )

06. Notification. The pharmacist must inquire about the identity of the patient's primary care provider; and, if one is identified by the patient, provide notification within five (5) business days following the prescribing of a drug. In the instance in which the pharmacist is prescribing to close a gap in care or to supplement a valid prescription drug order, the pharmacist must alternatively notify the provider of record. ( )

07. Documentation. The pharmacist must maintain documentation adequate to justify the care provided, including, but not limited to the information collected as part of the patient assessment, the prescription record, any notification provided as required under this section, and the follow-up care plan. ( )

021. PHARMACIST PRESCRIBING FOR MINOR CONDITIONS.
A pharmacist may prescribe any drug approved by the FDA that is indicated for the following conditions: ( )

01. Lice; ( )

02. Cold Sores; ( )

03. Motion Sickness *Prevention*; *and* *( )*

0*4*. Uncomplicated Urinary Tract Infections. *( )*

022. PHARMACIST PRESCRIBING OF DEVICES.
A pharmacist may prescribe any of the following devices approved by the FDA: ( )

01. Inhalation Spacer; ( )

02. Nebulizer; ( )

03. Diabetes Blood Sugar Testing Supplies; ( )

04. Pen Needles; and *( )*

05. Syringes. Syringes for patients with diabetes. ( )

023. PHARMACIST PRESCRIBING BASED ON CLIA-WAIVED TEST.
A pharmacist may prescribe any antimicrobial drug approved by the FDA that is indicated for the following conditions, provided the symptomatic patient first tests positive to a CLIA-waived test indicated for the condition: ( )

01. Influenza. When a person has tested positive for influenza, a pharmacist may additionally prescribe an antiviral medication to an individual who has been exposed to the infectious person and for whom clinical guidelines recommend chemoprophylaxis; and ( )

02. Group A Streptococcal Pharyngitis. ( )

024. PHARMACIST PRESCRIBING FOR CLINICAL GAPS IN CARE.
A pharmacist may prescribe any drug approved by the FDA for the purposes of closing a gap in clinical guidelines as follows: ( )

01. Statins. Statins, for patients *who have a current prescription for a drug for* diabetes; and *( )*

02. Short-Acting Beta Agonists. Short-acting beta agonists (SABA), for patients with asthma who have had a prior prescription for a SABA, and who have a current prescription for a long-term asthma control medication. ( )

025. PHARMACIST PRESCRIBING OF TRAVEL DRUGS.
A pharmacist who successfully completes an accredited CPE or CME course on travel medicine may prescribe any non-controlled drug recommended for individuals traveling outside the United States that are specifically listed in the federal CDC Health Information for International Travel (e.g., Yellow Book). The pharmacist may only prescribe drugs that are indicated for the patient's intended destination for travel. ( )

026. PHARMACIST PRESCRIBING TO SUPPLEMENT AN INFUSION ORDER.
A pharmacist may prescribe any of the following FDA approved drugs or devices to supplement a valid prescription drug order or institutional drug order for drugs intended to be administered to a patient via infusion; ( )

01. Flush. Heparin, in concentrations of 100 units per milliliter or less, and saline; ( )

02. Devices. Infusion pumps and other rate control devices; ( )

03. Supplies. Tubing, filters, catheters, intravenous (IV) start kits, central line dressing kits, and injection caps; and ( )

04. Local Anesthetics for IV Port Access. ( )

027. PHARMACIST PRESCRIBING IN EMERGENCY SITUATIONS.
If *in an emergency, after contacting emergency medical services,* a situation exists that, in the professional judgment of the pharmacist, threatens the health or safety of the patient, a pharmacist may prescribe the following FDA approved drugs in the minimum quantity necessary until the patient is able to be seen by another provider. *( )*

01. Diphenhydramine; ( )

02. **Epinephrine**; and ( )

03. **Short-Acting Beta Agonists**. ( )

028. PHARMACIST PRESCRIBING FOR LYME DISEASE PROPHYLAXIS.
After a recognized tick bite, a pharmacist may prescribe antimicrobial prophylaxis, for the prevention of Lyme disease in accordance with *current CDC* guidelines. *( )*

029. – 199. (RESERVED)

200. 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. ( )

a. Agreement Elements. The collaborative pharmacy practice agreement must include: ( )

i. Identification of the parties to the agreement; ( )

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; ( )

iii. The drug name, class or category and protocol, formulary, or clinical guidelines that describe or limit a pharmacist's authority to perform DTM; ( )

iv. A described method for a prescriber to monitor compliance with the agreement and clinical outcomes of patients and to intercede where necessary; ( )

v. A provision allowing any party to cancel the agreement by written notification; ( )

vi. An effective date; and ( )

vii. Signatures of the parties to the agreement and dates of signing. ( )

b. Agreement Review. The collaborative pharmacy practice agreement must be reviewed and revised when necessary or appropriate. ( )

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. ( )

03. **Prescribing Exemption**. The general requirements set forth in Section 020 of these rules do not apply to collaborative agreements and statewide protocol agreements. ( )

201. – 999. (RESERVED)

IDAPA 27 – BOARD OF PHARMACY

27.01.05 – RULES GOVERNING DRUG COMPOUNDING

DOCKET NO. 27-0105-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 441 through 449**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Alex Adams at (208) 334-2356.

DATED this 27th day of October, 2017.

Alex J. Adams, Pharm D, MPH
Executive Director
Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
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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: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Wednesday, October 25, 2017 – 9:00 a.m. (MDT)

Idaho State Capitol Building
Room WW53
700 West Jefferson Street
Boise, ID 83702

For those planning to attend the open public hearing, the Board will accept written and verbal comments. For all others not planning to attend the public hearing, written comments will be accepted by the Executive Director on or before close of business on October 24, 2017 as follows:

- Written comments received by October 20, 2017 will be included in the Board's distributed meeting material for consideration in advance of the hearing.
- Written comments received between October 21, 2017 and October 24, 2017 will be printed and provided to the Board at the open public hearing.

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

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

The scope of Chapter 27.01.05 is to establish rules related to drug compounding. This chapter is comprised of current rules related to compounding drug products, sterile product preparation, hazardous drug preparation, outsourcing facilities, and labeling of distributed compounded drug products. No substantive changes were made to these rules relative to the current ones, though the Board did correct some minor typos from existing rules.

These rules will take effect in their entirety on July, 1, 2018.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted in two separate open, public meetings on August 1, 2017 and August 30, 2017. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published under Docket No. 27-0101-1701 in the June 7, 2017 Idaho Administrative Bulletin, **Vol. 17-6, pages 54 through 56**, and in the August 2, 2017 Idaho Administrative Bulletin, **Vol. 17-8, pages 114 through 115**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams 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 25, 2017.

DATED this 30th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0105-1701

IDAPA 27
TITLE 01
CHAPTER 05

27.01.05. – RULES GOVERNING DRUG COMPOUNDING

000. LEGAL AUTHORITY.
This chapter is adopted under the legal authority of the Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code; the Idaho Pharmacy Act, the Idaho Wholesale Drug Distribution Act, and the Idaho Legend Drug Donation Act, Title 54, Chapter 17, Idaho Code; and specifically pursuant to Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, and 54-1763, Idaho Code. ( )

001. TITLE AND SCOPE.
In addition to the General Provisions set forth in "General Provisions," IDAPA 27.01.01, the following title and scope shall apply to these rules: ( )

01. **Title**. The title of this chapter is "Rules Governing Drug Compounding," IDAPA 27, Title 01, Chapter 05. ( )

02. **Scope**. The scope of this chapter includes, but is not limited to, provision for, and clarification of, the Board's assigned responsibility to regulate and control drug compounding. ( )

002. WRITTEN INTERPRETATIONS.
In accordance with Title 67, Chapter 52, Idaho Code, this agency may have written statements that pertain to the interpretation of, or to compliance with the rules of this chapter. Any such documents are available for public inspection and copying at cost at the Idaho Board of Pharmacy office. ( )

003. ADMINISTRATIVE PROCEEDINGS AND APPEALS.
Administrative proceedings and appeals are administered by the Board in accordance with the "Idaho Rules of Administrative Procedure of the Attorney General," IDAPA 04.11.01, Subchapter B -- Contested Cases, Rules 100 through 800. ( )

01. Place and Time for Filing. Documents in rulemakings or contested cases must be filed with the executive director of the Board at the Board office between the hours of 8 a.m. and 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

02. Manner of Filing. One (1) original of each document is sufficient for filing; however, the person or officer presiding over a particular rulemaking or contested case proceeding may require the filing of additional copies. A document may be filed with the Board by e-mail or fax if legible, complete, and received during the Board's office hours. The filing party is responsible for verifying with Board staff that an e-mail or fax was successfully and legibly received. ( )

004. INCORPORATION BY REFERENCE.
No documents have been incorporated by reference into these rules. ( )

005. BOARD OFFICE INFORMATION.

01. Street Address. The office is located at 1199 Shoreline Lane, Suite 303, Boise, Idaho. ( )

02. Mailing Address. The mailing address is P.O. Box 83720, Boise, Idaho 83720-0067. ( )

03. Telephone Number. The telephone number is (208) 334-2356. ( )

04. Fax Number. The fax number is (208) 334-3536. ( )

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006. PUBLIC RECORDS ACT COMPLIANCE.
Board of Pharmacy records and filings are subject to compliance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. ( )

007. OFFICIAL BOARD JOURNAL.
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008. – 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the definitions and abbreviations found at IDAPA 27.01.01.010 through 012 are applicable to these rules. ( )

011. – 099. (RESERVED)

100. COMPOUNDING DRUG PRODUCTS.
Any compounding that is not permitted herein is considered manufacturing. ( )

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: ( )

a. Compound positron emission tomography drugs; ( )

b. Radiopharmaceutics; ( )

c. The reconstitution of a non-sterile drug or a sterile drug for immediate administration; ( )

d. The addition of a flavoring agent to a drug product; and ( )

e. Product preparation of a non-sterile, non-hazardous drug according to the manufacturer's FDA approved labeling. ( )

02. General Compounding Standards. ( )

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. ( )

b. Certificate of Analysis (COA). Unless the active pharmaceutical ingredient complies with the standards of an applicable USP-NF monograph, a COA must be obtained for all active pharmaceutical ingredients procured for compounding and retained for a period of not less than three (3) years from the date the container is emptied, expired, returned, or disposed of. The following minimum information is required on the COA: ( )

i. Product name; ( )

ii. Lot number; ( )

iii. Expiration date; and ( )

iv. Assay. ( )

c. Equipment. Equipment and utensils must be of suitable design and composition and cleaned, sanitized, or sterilized as appropriate prior to use. ( )

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. ( )

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. ( )

04. Limited Compounding. ( )

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. ( )

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: ( )

i. It is medically warranted to provide an alternate ingredient, dosage form, or strength of significance; or ( )

ii. The commercial product is not reasonably available in the market in time to meet the patient’s needs. ( )

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. ( )

05. Drug Compounding Controls. ( )

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: ( )

i. Appropriate packaging, handling, transport, and storage requirements; ( )

ii. Accuracy and precision of calculations, measurements, and weighing; ( )

iii. Determining ingredient identity, quality, and purity; ( )

iv. Labeling accuracy and completeness; ( )

v. Beyond use dating; ( )

vi. Auditing for deficiencies, including routine environmental sampling, quality and accuracy testing, and maintaining inspection and testing records; ( )

vii. Maintaining environmental quality control; and ( )

viii. Safe limits and ranges for strength of ingredients, pH, bacterial endotoxins, and particulate matter. ( )

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. ( )

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: ( )

i. Production date; ( )

ii. Beyond use date; ( )

iii. List and quantity of each ingredient; ( )

iv. Internal control or serial number; and ( )

v. Initials or unique identifier of all persons involved in the process or the compounder responsible for the accuracy of these processes. ( )

101. STERILE PRODUCT PREPARATION.

01. Application. In addition to all other applicable rules in this chapter, including the rules governing Compounding Drug Products, these rules apply to all persons, including any business entity, engaged in the practice of sterile compounding and sterile prepackaging in or into Idaho. ( )

02. Dosage Forms Requiring Sterility. The sterility of compounded biologics, diagnostics, drugs, nutrients, and radiopharmaceuticals must be maintained or the compounded drug product must be sterilized when prepared in the following dosage forms: ( )

a. Aqueous bronchial and nasal inhalations, except sprays intended to treat bronchial mucosa only; ( )

b. Baths and soaks for live organs and tissues; ( )

c. Injections (for example, colloidal dispersions, emulsions, solutions, suspensions); ( )

d. Irrigations for wounds and body cavities; ( )

e. Ophthalmic drops and ointments; and ( )

f. Tissue implants. ( )

03. Compounder Responsibilities. Compounders and sterile prepackagers are responsible for ensuring that sterile products are accurately identified, measured, diluted, and mixed and are correctly purified, sterilized, packaged, sealed, labeled, stored, dispensed, and distributed, as well as prepared in a manner that maintains sterility and minimizes the introduction of particulate matter; ( )

a. Unless following manufacturer's guidelines or another reliable literature source, opened or partially used packages of ingredients for subsequent use must be properly stored as follows; ( )

i. Opened or entered (such as needle-punctured) single-dose containers, such as bags, bottles, syringes, and vials of sterile products and compounded sterile products shall be used within one (1) hour if opened in non-sterile conditions, and any remaining contents must be discarded; ( )

ii. Single-dose vials needle-punctured in a sterile environment may be used up to six (6) hours after initial needle puncture; ( )

iii. Opened single-dose ampules shall not be stored for any time period; and ( )

iv. Multiple-dose containers (for example, vials) that are formulated for removal of portions on multiple occasions because they contain antimicrobial preservatives, may be used for up to twenty-eight (28) days after initial opening or entering, unless otherwise specified by the manufacturer; ( )

b. Water-containing compounded sterile products that are non-sterile during any phase of the compounding procedure must be sterilized within six (6) hours after completing the preparation in order to minimize the generation of bacterial endotoxins; ( )

c. Food, drinks, and materials exposed in patient care and treatment areas shall not enter ante-areas, buffer areas, or segregated areas where components and ingredients of sterile products are prepared. ( )

04. Environmental Controls. Except when prepared for immediate administration, the environment for the preparation of sterile products in a drug outlet must be in an isolated area, designed to avoid unnecessary traffic and airflow disturbances, and equipped to accommodate aseptic techniques and conditions. ( )

a. Hoods and aseptic environmental control devices must be certified for operational efficiency as often as recommended by the manufacturer or at least every six (6) months or if relocated. ( )

b. Filters must be inspected and replaced in accordance with the manufacturer's recommendations. ( )

05. Sterile Product Preparation Equipment. A drug outlet in which sterile products are prepared

must be equipped with at least the following: ( )

a. Protective apparel including gowns, masks, and sterile (or the ability to sterilize) non-vinyl gloves, unless the PIC can provide aseptic isolator manufacturer's written documentation that any component of garbing is not required; ( )

b. A sink with hot and cold water in close proximity to the hood; ( )

c. A refrigerator for proper storage of additives and finished sterile products prior to delivery when necessary; and ( )

d. An appropriate laminar airflow hood or other aseptic environmental control device such as a laminar flow biological safety cabinet. ( )

06. Documentation Requirements. The following documentation must also be maintained by a drug outlet in which sterile products are prepared: ( )

a. Justification of beyond use dates assigned, pursuant to direct testing or extrapolation from reliable literature sources; ( )

b. Training records, evidencing that personnel are trained on a routine basis and are adequately skilled, educated, and instructed; ( )

c. Audits appropriate for the risk of contamination for the particular sterile product including: ( )

i. Visual inspection to ensure the absence of particulate matter in solutions, the absence of leakage from bags and vials, and the accuracy of labeling with each dispensing; ( )

ii. Periodic hand hygiene and garbing competency; ( )

iii. Media-fill test procedures (or equivalent), aseptic technique, and practice related competency evaluation at least annually by each compounder or sterile prepackager; ( )

iv. Environmental sampling testing at least upon registration of a new drug outlet, following the servicing or re-certification of facilities and equipment, or in response to identified problems with end products, staff techniques or patient-related infections, or every six (6) months, including: ( )

(1) Total particle counts; ( )

(2) Viable air sampling; ( )

(3) Gloved fingertip sampling; ( )

(4) Surface sampling; ( )

v. Sterility testing of high risk batches of more than twenty-five (25) identical packages (ampules, bags, vials, etc.) before dispensing or distributing; ( )

d. Temperature, logged daily; ( )

e. Beyond use date and accuracy testing, when appropriate; and ( )

f. Measuring, mixing, sterilizing, and purification equipment inspection, monitoring, cleaning, and maintenance to ensure accuracy and effectiveness for their intended use. ( )

07. Policies and Procedures. Policies and procedures appropriate to the practice setting must be adopted by a drug outlet preparing sterile pharmaceutical products and must include a continuous quality

improvement program for monitoring personnel qualifications and training in sterile technique, including: ( )

a. Antiseptic hand cleansing; ( )

b. Disinfection of non-sterile compounding surfaces; ( )

c. Selecting and appropriately donning protective garb; ( )

d. Maintaining or achieving sterility of sterile products while maintaining the labeled strength of active ingredients; ( )

e. Manipulating sterile products aseptically, including mixing, diluting, purifying, and sterilizing in the proper sequence; ( )

f. Choosing the sterilization method, pursuant to the risk of a contamination of particular compounded sterile product; and ( )

g. Inspecting for quality standards before dispensing or distributing. ( )

102. HAZARDOUS DRUGS PREPARATION.
In addition to all other applicable rules in this chapter, including the rules governing Compounding Drug Products and Sterile Product Preparation, these rules apply to all persons, including any business entity, engaged in the practice of compounding or sterile prepackaging with hazardous drugs. Such persons must: ( )

01. Ventilation. Ensure the storage and compounding areas have sufficient general exhaust ventilation to dilute and remove any airborne contaminants. ( )

02. Ventilated Cabinet. Utilize a ventilated cabinet designed to reduce worker exposures while preparing hazardous drugs. ( )

a. Sterile hazardous drugs must be prepared in a dedicated Class II biological safety cabinet or a barrier isolator of appropriate design to meet the personnel exposure limits described in product material safety data sheets; ( )

b. When asepsis is not required, a Class I BSC, powder containment hood or an isolator intended for containment applications may be sufficient. ( )

c. A ventilated cabinet that re-circulates air inside the cabinet or exhausts air back into the room environment is prohibited, unless: ( )

i. The hazardous drugs in use will not volatilize while they are being handled; or ( )

ii. The PIC can provide manufacturer written documentation attesting to the safety of such ventilation. ( )

03. Clear Identification. Clearly identify storage areas, compounding areas, containers, and prepared doses of hazardous drugs. ( )

04. Labeling. Label hazardous drugs with proper precautions, and dispense them in a manner to minimize risk of hazardous spills. ( )

05. Protective Equipment and Supplies. Provide and maintain appropriate personal protective equipment and supplies necessary for handling hazardous drugs, spills and disposal. ( )

06. Contamination Prevention. Unpack, store, prepackage, and compound hazardous drugs separately from other inventory in a restricted area in a manner to prevent contamination and personnel exposure until hazardous drugs exist in their final unit dose or unit-of-use packaging. ( )

07. Compliance With Laws. Comply with applicable local, state, and federal laws including for the disposal of hazardous waste. ( )

08. Training. Ensure that personnel working with hazardous drugs are trained in hygiene, garbing, receipt, storage, handling, transporting, compounding, spill control, clean up, disposal, dispensing, medical surveillance, and environmental quality and control. ( )

09. Policy and Procedures Manual. Maintain a policy and procedures manual to ensure compliance with this rule. ( )

103. OUTSOURCING FACILITY.

01. Federal Act Compliance. An outsourcing facility must ensure compliance with 21 U.S.C. Section 353b of the Federal Food, Drug and Cosmetic Act. ( )

02. Adverse Event Reports. Outsourcing facilities must submit a copy of all adverse event reports submitted to the secretary of Health and Human Services in accordance with the content and format requirement established in Section 310.305 of Title 21 of the Code of Federal Regulations to the Board. ( )

03. Policies and Procedures. An outsourcing facility must adopt policies and procedures for maintaining records pertaining to compounding, process control, labeling, packaging, quality control, distribution, complaints, and any information required by state or federal law. ( )

104. LABELING: DISTRIBUTED COMPOUNDED DRUG PRODUCT.
Compounded and sterile prepackaged drug product distributed in the absence of a patient specific prescription drug order, solely as permitted for outsourcing facilities and pharmacies herein, must be labeled with the following information: ( )

01. Drug Name. The name of each drug included. ( )

02. Strength or Concentration. The strength or concentration of each drug included. ( )

03. Base or Diluents. If a sterile compounded drug product, the name and concentration of the base or diluents. ( )

04. Administration. If applicable, the dosage form or route of administration. ( )

05. Quantity. The total quantity of the drug product. ( )

06. Expiration Date. The expiration or beyond use date. ( )

07. Compounder Identifier. The initials or unique identifier of the compounder responsible for the accuracy of the drug product. ( )

08. Resale Prohibited. Resale is prohibited and products must be labeled as follows: ( )

a. A pharmacy that is distributing, the statement: “not for further dispensing or distribution;” and ( )

b. An outsourcing facility, the statement: “not for resale.” ( )

09. Instructions, Cautions, and Warnings. Handling, storage or drug specific instructions, cautionary information, and warnings as necessary or appropriate for proper use and patient safety. ( )

105. – 999. (RESERVED)

IDAPA 27 – BOARD OF PHARMACY

27.01.06 – RULES GOVERNING DME, MANUFACTURING, AND DISTRIBUTION

DOCKET NO. 27-0106-1701 (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 2018 Idaho State Legislature for final approval. The pending rule becomes final and effective July 1, 2018, unless the rule is approved or rejected in part by concurrent resolution in accordance with Sections 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 4, 2017 Idaho Administrative Bulletin, **Vol. 17-10, pages 450 through 457**.

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

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Alex Adams at (208) 334-2356.

DATED this 27th day of October, 2017.

Alex J. Adams, Pharm D, MPH
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 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: A public hearing concerning this rulemaking will be held as follows:

PUBLIC HEARING
Wednesday, October 25, 2017 – 9:00 a.m. (MDT)

Idaho State Capitol Building
Room WW53
700 West Jefferson Street
Boise, ID 83702

For those planning to attend the open public hearing, the Board will accept written and verbal comments. For all others not planning to attend the public hearing, written comments will be accepted by the Executive Director on or before close of business on October 24, 2017 as follows:

- Written comments received by October 20, 2017 will be included in the Board's distributed meeting material for consideration in advance of the hearing.
- Written comments received between October 21, 2017 and October 24, 2017 will be printed and provided to the Board at the open public hearing

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

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

The scope of Chapter 27.01.06 is to establish rules to regulate durable medical equipment (DME), manufacturing, and distribution. This chapter is comprised of current rules as follows: DME outlet standards, drug distribution, wholesaler standards, and drug manufacturer standards. No substantive changes were made to these rules relative to the current ones, though the following conforming edits have been made:

- The Board proposes to remove the transaction restriction on non-prescription drugs, which coincides with the removal of registration of non-pharmacy retail outlets specified in Chapter 02, IDAPA 27.01.02; and
- The Board proposes to amend the restriction on delivering drugs only to "the premises listed on the authorized receiving person's license or registration" to "the registered address" to reflect recent changes in what is on a state license and registration.

These rules will take effect in their entirety on July 1, 2018.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted in two separate open, public meetings on August 1, 2017and August 30, 2017. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published under Docket No. 27-0101-1701 in the June 7, 2017 Idaho Administrative Bulletin, **Vol. 17-6, pages 54 through 56**, and in the August 2, 2017 Idaho Administrative Bulletin, **Vol. 17-8, pages 114 through 115**.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Alex Adams 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 25, 2017.

DATED this 30th day of August, 2017.

LSO Rules Analysis Memo

THE FOLLOWING IS THE TEXT OF DOCKET NO. 27-0106-1701

IDAPA 27
TITLE 01
CHAPTER 06

27.01.06. – RULES GOVERNING DME, MANUFACTURING, AND DISTRIBUTION

000. LEGAL AUTHORITY.
This chapter is adopted under the legal authority of the Uniform Controlled Substances Act, Title 37, Chapter 27, Idaho Code; the Idaho Pharmacy Act, the Idaho Wholesale Drug Distribution Act, and the Idaho Legend Drug Donation Act, Title 54, Chapter 17, Idaho Code; and specifically pursuant to Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, and 54-1763, Idaho Code. ( )

001. TITLE AND SCOPE.
In addition to the General Provisions set forth in "General Provisions," IDAPA 27.01.01, the following title and scope shall apply to these rules: ( )

01. Title. The title of this chapter is "Rules Governing DME, Manufacturing, and Distribution," IDAPA 27, Title 01, Chapter 06. ( )

02. Scope. The scope of this chapter includes, but is not limited to, provision for, and clarification of, the Board's assigned responsibility to regulate and control drug manufacturing and distribution. ( )

002. WRITTEN INTERPRETATIONS.

In accordance with Title 67, Chapter 52, Idaho Code, this agency may have written statements that pertain to the interpretation of, or to compliance with the rules of this chapter. Any such documents are available for public inspection and copying at cost at the Idaho Board of Pharmacy office. ( )

003. ADMINISTRATIVE PROCEEDINGS AND APPEALS.
Administrative proceedings and appeals are administered by the Board in accordance with the "Idaho Rules of Administrative Procedure of the Attorney General," IDAPA 04.11.01, Subchapter B -- Contested Cases, Rules 100 through 800. ( )

01. Place and Time for Filing. Documents in rulemakings or contested cases must be filed with the executive director of the Board at the Board office between the hours of 8 a.m. and 5 p.m., Mountain Time, Monday through Friday, excluding state holidays. ( )

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004. INCORPORATION BY REFERENCE.
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007. OFFICIAL BOARD JOURNAL.
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008. – 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the definitions and abbreviations found at IDAPA 27.01.01.010 through 012 are applicable to these rules. ( )

011. – 019. (RESERVED)

020. DME OUTLET STANDARDS.

01. Policies and Procedures. A DME outlet must adopt policies and procedures that establish: ( )

a. Operational procedures for the appropriate provision and delivery of equipment; ( )

b. Operational procedures for maintenance and repair of equipment; and ( )

c. Recordkeeping requirements for documenting the acquisition and provision of products. ( )

02. Sale of Specified Prescription Drugs. Registered DME outlets may hold for sale at retail the following prescription drugs: ( )

a. Pure oxygen for human application; ( )

b. Nitrous oxide; ( )

c. Sterile sodium chloride; and ( )

d. Sterile water for injection. ( )

03. Prescriber's Order Required. Prescription drugs and devices may only be sold or delivered by a DME outlet upon the lawful order of a prescriber. ( )

021. -- 029. (RESERVED)

030. DRUG DISTRIBUTION.

01. Authorized Distributors. The following drug outlets may distribute legend drugs in or into Idaho, in compliance with these rules, pursuant to the following restrictions: ( )

a. A licensed or registered wholesale distributor and a registered manufacturer in compliance with the Idaho Wholesale Distribution Act and the Idaho Pharmacy Act; ( )

b. An FDA and Idaho registered outsourcing facility in compliance with 21 U.S.C. Section 353b of the Food, Drug and Cosmetic Act; ( )

c. A dispenser without being licensed or registered as a wholesale distributor according to the following restrictions: ( )

i. A dispenser may distribute to authorized recipients for an emergency medical purpose in which an alternative source for a drug is not reasonably available in sufficient time to prevent risk of harm to a patient that would result from a delay in obtaining a drug. The amount of the drug distributed in an emergency must not reasonably exceed the amount necessary for immediate use; ( )

ii. A dispenser may distribute intracompany to any division, subsidiary, parent, affiliated or related company under common ownership and control of a corporate entity; ( )

iii. A dispenser may distribute to another dispenser pursuant to a sale, transfer, merger or consolidation of all or a part of a dispenser, whether accomplished as a sale of stock or business assets; ( )

iv. A dispenser may distribute compound positron emission tomography drugs or radiopharmaceutics, if in compliance with applicable federal law; and ( )

v. A dispenser may distribute minimal quantities of prescription drugs to a prescriber for in-office administration, including the distribution of compounded drug product in the absence of a patient specific prescription drug order if: ( )

(1) The compounded drug product is not sterile and not intended to be sterile; ( )

(2) The compounded drug product is not further dispensed or distributed by the practitioner; and ( )

(3) The quantity of compounded drug product distributed is limited to five percent (5%) of the total number of compounded drug products dispensed and distributed on an annual basis by the dispenser, which may include a drug compounded for the purpose of, or incident to, research, teaching or chemical analysis. ( )

02. Distribution. Unless statutorily exempted, an authorized distributor must furnish: ( )

a. Drug product only to a person licensed by the appropriate state licensing agency to dispense, conduct research with or independently administer such drugs; ( )

b. Scheduled controlled substances only to a person who has been issued a valid controlled substance registration by the DEA and the Board, unless exempt by state or federal law; ( )

c. Federally required transaction documentation, including transaction information, transaction history, and transaction statements with each distribution; and ( )

d. Drug product only to the registered address of the authorized receiving person. Delivery to a hospital pharmacy receiving area satisfies this requirement, provided that authorized receiving personnel sign for receipt at the time of delivery. ( )

03. Controlled Substance Distribution Invoice. Distributions must be pursuant to an invoice and not a prescription drug order. For controlled substances, each dispenser must retain a signed receipt of the distribution that includes at least: ( )

a. The date of the transaction; ( )

b. The name, address, and DEA registration number of the distributing dispenser; ( )

c. The name, address, and DEA registration number of the receiving dispenser; ( )

d. The drug name, strength, and quantity for each product distributed; and ( )

e. The signature of the person receiving the drugs. ( )

04. Monitoring Purchase Activity. An authorized distributor must have adequate processes in place for monitoring purchase activity of customers and identifying suspicious ordering patterns that identify potential diversion or criminal activity related to controlled substances such as orders of unusual size, orders deviating substantially from a normal pattern, orders for drugs that are outside of the prescriber's scope of practice, and orders of unusual frequency. ( )

05. Reporting. An authorized distributor must report specified data on controlled substances distributed at least monthly to the Board in a form and manner prescribed by the Board, except when distributing intracompany. ( )

06. Prohibited Acts. The following acts are prohibited: ( )

a. Distribution of any drug product that is adulterated, misbranded, counterfeit, expired, damaged, recalled, stolen, or obtained by fraud or deceit; and ( )

b. Failing to obtain a license or registration when one is required to distribute in or into Idaho. ( )

031. -- 039. (RESERVED)

040. WHOLESALER: STANDARDS.

These wholesaler rules establish the minimum standards for the storage and handling of drugs by wholesalers and their officers, designated representative, agents, and employees and for the establishment and maintenance of records required for persons engaged in wholesale drug distribution. ( )

041. WHOLESALER: FACILITY REQUIREMENTS.
Facilities where drugs are stored, warehoused, handled, held, offered, marketed, or displayed for wholesale distribution must: ( )

01. Minimum Physical Standards. Be of suitable size, construction, and location to accommodate cleaning, maintenance, and proper operations; ( )

02. Minimum Environmental Standards. Have adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions; ( )

03. Quarantine Area. Have a quarantine area for storage of drugs that are outdated, damaged, deteriorated, misbranded, or adulterated or that are in immediate or sealed secondary containers that have been opened; ( )

04. Maintenance Requirements. Be maintained in a clean and orderly condition; and ( )

05. Pest Controls. Be free from infestation by insects, rodents, birds, or vermin of any kind. ( )

042. WHOLESALER: FACILITY SECURITY.
Facilities used for wholesale drug distribution must be secure from unauthorized entry, as follows: ( )

01. Access from Outside. Access from outside the premises must be kept to a minimum and well controlled; ( )

02. Perimeter Lighting. The outside perimeter of the premises must be well lighted; ( )

03. Authorized Entry. Entry into areas where drugs are held must be limited to authorized personnel; ( )

04. Alarm Systems. Facilities must be equipped with an alarm system to detect entry after hours; and ( )

05. Security Systems. Facilities must be equipped with security systems sufficient to protect against theft, diversion, and record tampering. ( )

043. WHOLESALER: DRUG STORAGE REQUIREMENTS.
Drugs must be stored at temperatures and under conditions required by the labeling of the drugs, if any, or by current requirements of the USP-NF, to preserve product identity, strength, quality, and purity. Temperature and humidity recording equipment, devices, or logs must document proper storage of drugs. ( )

044. WHOLESALER DRUG SHIPMENT INSPECTION REQUIREMENTS.

01. Examination on Receipt. Each shipping container must be visually examined on receipt for identity and to avoid acceptance of drugs that are contaminated or otherwise unfit for distribution. ( )

02. Outgoing Shipment Inspections. Outgoing shipments must be inspected to verify the accuracy and product integrity of the shipment contents. ( )

045. WHOLESALER: QUARANTINE.
Drugs that are outdated, damaged, deteriorated, misbranded, or adulterated must be physically separated from other drugs in a designated quarantine area until destroyed or returned to the original manufacturer or third party returns processor. ( )

01. Container Adulteration. Used drugs and those whose immediate or sealed outer or sealed secondary containers have been opened are adulterated and must be quarantined. ( )

02. Other Conditions Requiring Quarantine. Drugs must be quarantined under any condition that causes doubt as to a drug's safety, identity, strength, quality, or purity unless under examination, testing, or other investigation the drug is proven to meet required standards. ( )

046. WHOLESALER: RECORDKEEPING REQUIREMENTS.
Wholesalers and other entities engaged in wholesale drug distribution must establish and maintain inventories and records of transactions pertaining to the receipt and distribution or other disposition of drugs. ( )

01. Record Contents. The records must include at least: ( )

a. The source of the drugs, including the name and principal address of the seller or transferor, and the address of the location from which the drugs were shipped; ( )

b. The identity and quantity of the drugs received and distributed or disposed of; and ( )

c. The dates of receipt and distribution or other disposition of the drugs. ( )

02. Records Maintenance. Records may be maintained in an immediately retrievable manner at the inspection site or in a readily retrievable manner at a central location. ( )

047. WHOLESALER: PERSONNEL.

01. Responsible Person Designees. A wholesaler must establish and maintain a list of officers, directors, managers, a designated representative, and other persons responsible for wholesale drug distribution, storage, and handling and must include a description of each individual's duties and a summary of their qualifications. ( )

02. Adequate Personnel. A wholesaler must employ personnel in sufficient numbers and with adequate education, training, and experience to safely and lawfully engage in wholesale drug distribution activities. ( )

03. Designated Representative Continuing Education. A wholesaler's designated representative must complete training and continuing education on state and federal laws pertaining to wholesale distribution of prescription drugs provided by qualified in-house specialists, outside counsel, or consulting specialists with capabilities to help ensure compliance. ( )

048. WHOLESALER: POLICIES AND PROCEDURES.
Wholesalers must adopt policies and procedures for the receipt, security, storage, inventory, and distribution of drugs, including policies and procedures for identifying, recording, and reporting losses or thefts, for correcting errors and inaccuracies in inventories, and as necessary to ensure compliance with the following: ( )

01. Distribution of Oldest Approved Stock First. The oldest approved stock of a drug product must be distributed first except if extraordinary circumstances require a temporary deviation. ( )

02. Recalls and Withdrawals. Drugs must be recalled or withdrawn upon: ( )

a. A request by the FDA or other local, state, or federal law enforcement or other government agency, including the Board; ( )

b. A voluntary action by a manufacturer to remove defective or potentially defective drugs from the market; or ( )

c. An action undertaken to promote public health and safety by replacing existing merchandise with an improved product or a new package design. ( )

03. Crisis Preparation. Wholesalers must prepare for, protect against, and competently handle a crisis affecting the security or operation of a facility, including a fire, flood, or other natural disaster, a strike, or other situations of local, state, or national emergency. ( )

049. (RESERVED)

050. DRUG MANUFACTURERS.
These rules are applicable to drug manufacturers located within the state of Idaho. Non-resident manufacturers engaged in wholesale drug distribution in or into Idaho must comply with the Idaho Wholesale Drug Distribution Act and rules, as applicable. ( )

01. Standards. A manufacturer must ensure compliance with the federal "Current Good Manufacturing Practice" requirements. ( )

02. Records. A manufacturer must adopt policies and procedures for maintaining records pertaining to production, process control, labeling, packaging, quality control, distribution, complaints, and any information required by state or federal law. ( )

051. -- 999. (RESERVED)