PENDING RULES

COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

House Health & Welfare Committee

66th Idaho Legislature
First Regular Session – 2021

Prepared by:

Office of the Administrative Rules Coordinator
Division of Financial Management

January 2021

BRAD LITTLE
Governor

ALEX J. ADAMS
Administrator

State of Idaho
DIVISION OF FINANCIAL MANAGEMENT
Executive Office of the Governor

January 11, 2021

M E M O R A N D U M

TO: **Members of the 2021 Idaho State Legislature**

FROM: **Alex J. Adams, Administrator**
Bradley A. Hunt, Rules Coordinator

SUBJECT: **Overview of Executive Agency Rulemaking in 2020**

Background. Governor Little initiated a rules moratorium for calendar year 2020 and thus the volume of rulemaking is down substantially relative to most years. Most rules published in the Legislative Rules Review book are simply re-published because the 2020 Legislature adjourned *sine die* without passing a concurrent resolution approving any pending fee rules as specified in Section 67-5224, Idaho Code. The necessary fee rules were re-published in the following special bulletins:

- April 15 – Temporary Fee Rules
- September 16 – Proposed Fee Rules
- November 18 – Pending Fee Rules

Changes in Existing Fee Rules. Since all fee rules expired upon sine die, there is no existing rule available to amend. Therefore, only a clean version of the rule chapter is able to be presented to the Legislature in January 2021. In some cases, fee rules were modified based on public comment, or to implement Executive Order 2020-13, among other reasons. Given the unprecedented volume, all edits are incorporated within a single docket and presented as a clean fee rule chapter. There are several ways that legislators may view previous rules for comparison purposes:

- An archive of any rule since 1996 is available on the DFM website. This allows legislators to see the evolution of a rule over time.
- The Legislative Services Office analyzes all proposed rules. You can find their analysis of proposed rules which, in some cases, may discuss changes to rules between sine die and the proposed rules. These may be found on the Legislature's website.
- Changes made between the proposed and pending rule stages were noted in the November 18th bulletin where applicable.

Process for Approving/Extending Rules. Below, you will find a brief description on legislative actions and outcomes regarding the rules review process and contents of the Legislative Rules Review Books:

- Pending Fee Rules must be affirmatively approved by both bodies via adoption of concurrent resolution to become final.
- Temporary Rules must be affirmatively approved by both bodies via adoption of concurrent resolution to be extended.
- Pending Rules become final and effective sine die unless rejected, in whole or in part, via concurrent resolution adopted by both bodies.
    - Pending rules may be approved, in whole or in part, or rejected if determined to be inconsistent with legislative intent of the governing statute.
    - If rejected, new or amended language must be identified at a numerical or alphabetical designation within the rule and specified in the concurrent resolution.
- A link to LSO's proposed rule analysis is provided at the beginning of each docket and includes any required supporting documentation (e.g. Cost Benefit Analysis (CBA), Incorporation By Reference Synopsis (IBRS)) as part of the analysis.
- All 2021 review books can be accessed on the DFM website here.

Contact Information. If questions arise during the rules review process, please do not hesitate to contact the Rules Coordinator, Brad Hunt: Brad.Hunt@dfm.idaho.gov; 208-854-3096.

HOUSE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Proposed Rule Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2021 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-2401(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.

The Governor's Executive Order 2020-13 resulted in agencies reviewing temporarily waived rules that can be eliminated. These proposed changes will align state licensure with Federal regulations (CARES Act, Section 3708) allowing Licensed Independent Practitioners to order home health services and follow patients.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2020, Idaho Administrative Bulletin, Vol. 20-9, pages 51 through 60.

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 the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Debby Ransom at (208) 334-6626.

Dated this 18th day of November, 2020.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
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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 39-2401(2), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2020.

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 Governor's Executive Order 2020-13 resulted in agencies reviewing temporarily waived rules that can be eliminated. These changes removing elements from Subsections 010, 022.02.d-f, 030.4-7, and 031.03, will align state licensure with Federal regulations (CARES Act, section 3708) allowing Licensed Independent Practitioners to order home health services and follow patients.

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 or general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these changes reduce the regulatory burden for providers.

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 Debby Ransom at (208) 334-6626.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2020.

Dated this 23rd day of July, 2020.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0307-2001

010. DEFINITIONS.

01. Abuse. Any conduct as a result of which (a person) suffers skin bruising, bleeding, malnutrition, sexual molestation, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive or death, or mental injury, and such condition or death is not justifiably explained, or where the history given concerning such condition or death is at variance with the degree or type of such condition or death, or the circumstances indicate that such condition or death, may not be the product of accidental occurrence. (Idaho Code, Title 39, Chapter 5202(2). (7-1-93)

02. Administrator. The person appointed by the governing body delegated the responsibility for managing the (HHA). (3-20-20)

03. Audiologist. A person who is licensed by the Idaho Bureau of Occupational Licenses to provide audiology services. (3-20-20)

04. Audit. A methodical examination and review. (12-31-91)

05. Board. The Idaho State Board of Health and Welfare. (12-31-91)

06. Branch Office. A location from which a HHA provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the HHA and must be sufficiently close to the parent agency that it is not impractical for it to receive administration, supervision and services from the parent agency. The branch office is not required to independently meet the requirements for licensure. (7-1-93)

07. Business Entity. A public or private organization owned or operated by one (1) or more persons. (7-1-93)

08. Patient. An individual who is a recipient of provided health care services. (3-20-20)

09. Clinical Note. A notation of a contact with or regarding a patient that is written and dated by a member of the health team. (7-1-93)

10. Clinical Record. A legal document containing all pertinent information relating to a patient. (7-1-93)

11. Complaint Investigation. An investigation by an agency to determine the validity of an allegation against it. (3-20-20)

12. Complaint Survey. On-site inspection conducted by the Department to investigate an allegation against an agency. (7-1-93)

13. Deficiency. A determination of noncompliance with a specific rule or part of a rule. (7-1-93)

14. Department. The Idaho Department of Health and Welfare. (7-1-93)

15. Directly. Providing home health services either through salaried employees or through personnel under hourly or per visit contracts. (7-1-93)

16. Director. A physician or licensed registered nurse responsible for general supervision, coordination, and direction of patient care in an HHA. (3-20-20)

17. Follow-Up Survey. A survey made to determine if corrections have been made to deficiencies cited in an earlier survey. Areas surveyed are determined by the nature of the deficiencies cited during the previous survey although new deficiencies may be cited in any area. (7-1-93)

18. Governing Body. The designated person or persons who assume full responsibility for the conduct

and operation of the HHA. (3-20-20)

19. Government Unit. The state, or any county, municipality, or other political subdivision, or any department, division, board or other agency thereof. (7-1-93)

20. Grievance Procedure. A method to ensure patient rights by receiving, investigating, resolving, and documenting complaints related to the provision of services of the HHA. (3-20-20)

21. Group of Professional Personnel. A group which includes, at least, one (1) physician, at least, one (1) licensed registered nurse, and other health professionals representing at least the scope of the program, agency staff, and others. (7-1-93)

22. Health Care Services. Any of the following services that are provided at the residence of an individual: (7-1-93)

a. Skilled nursing services; (7-1-93)

b. Homemaker/home health aide services; (7-1-93)

c. Physical therapy services; (7-1-93)

d. Occupational therapy services; (7-1-93)

e. Speech therapy services; (7-1-93)

f. Nutritional Services/Registered Dietitian Services; (7-1-93)

g. Respiratory therapy services; (7-1-93)

h. Medical/social services; (7-1-93)

i. Intravenous therapy services; and (7-1-93)

j. Such other services as may be authorized by rule of the Board. (7-1-93)

23. Home Health Agency (HHA). Any business entity that primarily provides skilled nursing services by licensed nurses and at least one (1) other health care service as defined in Subsection 010.22 to a patient in that patient's place of residence. Any entity that has a provider agreement with the Department as a personal assistance agency under Title 39, Chapter 56, Idaho Code, requires licensure as an HHA only if it primarily provides nursing services. (3-20-20)

24. Homemaker/Home Health Aide. A person who has successfully completed a basic prescribed course or its equivalent. (3-20-20)

25. Individual. A natural person who is a recipient of provided health care services. (7-1-93)

26. Licensed Independent Practitioner (LIP). A person who is: ( )

a. A licensed physician or physician assistant under Section 54-1803, Idaho Code; or ( )

b. A licensed advance practice registered nurse or Certified Nurse Specialist under Section 54-1402, Idaho Code. ( )

267. Licensed Practical Nurse. A person who is duly licensed pursuant to Title 54, Chapter 14 of the Idaho Code. (7-1-93)

278. Licensing Agency. The Department of Health and Welfare. (12-31-91)

28~~8~~9. Medical Equipment and Supplies. Items, which due to their therapeutic or diagnostic characteristics, are essential to provide patient care. (7-1-93)

~~29~~30. Neglect. The negligent failure to provide those goods or services which are reasonably necessary to sustain the life and health of a person. {Idaho Code, Title 39, Chapter 5302 (8)}. (7-1-93)

3~~0~~1. Occupational Therapist. A person licensed by the Idaho Bureau of Occupational Licenses to provide occupational therapy services. (3-20-20)

3~~1~~2. Occupational Therapy Assistant. A person certified by the Idaho Bureau of Occupational Licenses to provide occupational therapy services under the supervision of an occupational therapist. (3-20-20)

3~~2~~3. Parent Unit. The part of the HHA which develops and maintains administrative and professional control of branch offices. Services are provided by the parent unit. (3-20-20)

3~~3~~4. Physical Therapist. A person licensed by the Idaho Bureau of Occupational Licenses to provide physical therapy services. (3-20-20)

3~~4~~5. Physical Therapy Assistant. A person certified by the Idaho Bureau of Occupational Licenses to provide physical therapy services under the supervision of a physical therapist. (3-20-20)

3~~5~~6. Physician. Any person licensed as required by Title 54, Chapter 18, of the Idaho Code. (7-1-93)

3~~6~~7. Place of Residence. Wherever a patient makes their home. This may be a dwelling, an apartment, a relative's home, a residential care facility, a retirement center, or some other type of institution exclusive of licensed facilities which provide skilled nursing care. (7-1-93)

3~~7~~8. Progress Note. A written notation, dated and signed by a member of the health team, that documents facts about the patient's assessment, care provided, and the patient's response during a given period of time. (7-1-93)

3~~8~~9. Registered Dietitian. A person who is licensed by the Idaho Board of Medicine as a registered dietitian. (3-20-20)

~~39~~40. Licensed Registered Nurse (RN). A person who is duly licensed pursuant to Title 54, Chapter 14 of the Idaho Code. (7-1-93)

4~~0~~1. Regulation. A requirement established by state, federal, or local governments pursuant to law and having the effect of law. (7-1-93)

4~~1~~2. Respiratory Therapist. A person who is duly licensed by the Idaho Board of Medicine. (3-20-20)

4~~2~~3. Skilled Nursing Services. Those services provided directly by a licensed nurse for the purpose of promoting, maintaining, or restoring the health of an individual or to minimize the effects of injury, illness, or disability. (7-1-93)

4~~3~~4. Social Services. Those services provided by a person currently licensed by the Bureau of Occupational Licenses as a social worker in the state of Idaho. (12-31-91)

4~~4~~5. Speech Therapist. A person who is licensed by the Idaho Bureau of Occupational Licenses to provide speech, hearing, and communication services. (3-20-20)

4~~5~~6. Summary of Care Report. The compilation of the pertinent factors of a patient's clinical and progress notes that is submitted to the patient's ~~*physician*~~ licensed independent practitioner. ~~(7-1-93)~~( )

4~~6~~7. Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a

function or activity. (7-1-93)

4~~7~~8. Under Arrangement. Furnishing home health services through contractual or affiliation arrangements with other agencies, organizations or persons. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

020. ADMINISTRATION - GOVERNING BODY.

01. Scope. The HHA must be organized under a governing body, which assumes full legal responsibility for the conduct of the agency. (3-20-20)

02. Structure. The administrative responsibilities of the agency must be documented by means of a current organizational chart. (7-1-93)

03. Responsibilities. The governing body must assume responsibility for: (7-1-93)

a. Adopting appropriate bylaws and policies and procedures. (7-1-93)

b. Appointing the group of professional personnel. (3-20-20)

c. Appointing an administrator qualified to carry out the agency's overall responsibilities in relation to written goals and objectives and applicable state and federal laws. The administrator participates in deliberation and policy decisions concerning all services. (7-1-93)

d. Providing a continuing and annual program of overall agency evaluation. (11-19-76)

e. Assuring that appropriate space requirements, support services, and equipment for staff to carry out assigned responsibilities. (11-19-76)

f. Assuring that an agency having one or more branches providing service and located in a geographic area which varies from a centralized administrative area, provides, on a regular basis, supervision and guidance relating to all activities so as to maintain the entire agency on an equitable basis. (7-1-93)

g. Assuring that branches are held to the same standards and policies as the parent organization. Services offered by branches are specified in writing. Branches do not need to offer the same services as the parent agency. (7-1-93)

h. Seeking and promoting sources of reimbursement for home health services which will provide for the patient's economic protection. (7-1-93)

i. Cooperating in establishing a system by which to coordinate and provide continuity of care within the community served. (11-19-76)

j. Assuring that services will be provided directly or under arrangement with another person, agency or organization. Overall administrative and supervisory responsibility for services provided under arrangement rests with HHA. The HHA ensures that legal ~~*physician*~~ licensed independent practitioner's orders are carried out regardless of whether the service is provided directly or under arrangement. The HHA and it's staff, including staff services under arrangement, must operate and furnish services in accordance with all applicable federal, state, and local laws. ~~*(3-20-20)*~~( )

04. Patients' Rights. Ensure that patients' rights are recognized and must include as a minimum the following: (3-20-20)

a. Home health providers have an obligation to protect and promote the exercise of these rights. The

governing body of the agency must ensure patients' rights are recognized. (3-20-20)

b. A patient has a right to be informed of his rights and has a right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient's bill of rights will be included in the patient's medical record. (7-1-93)

c. A patient has the right to exercise his rights as a patient of the HHA. A patient's family or guardian may exercise a patient's rights when a patient has been judged incompetent. (7-1-93)

d. A patient's rights must include at a minimum the following: (7-1-93)

i. A patient has the right to courteous and respectful treatment, privacy, and freedom from abuse and neglect. (7-1-93)

ii. A patient has the right to be free from discrimination because of race, creed, color, sex, national origin, sexual orientation, and diagnosis. (7-1-93)

iii. A patient has the right to have his property treated with respect. (7-1-93)

iv. A patient has the right to confidentiality with regard to information about his health, social and financial circumstances and about what takes place in his home. (7-1-93)

v. The HHA will only release information about a patient as required by law or authorized by a patient. (7-1-93)

vi. A patient has the right to access information in his own record upon written request within two (2) working days. (7-1-93)

vii. A patient has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so. (7-1-93)

viii. The HHA investigates complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and documents both the existence of the complaint and the resolution of the complaint. (7-1-93)

ix. A patient has the right to be advised of the availability of the toll-free HHA hotline in the state. When the agency accepts a patient for treatment or care, the HHA advises the patient in writing of the telephone number of the home health hotline established by the state, the hours of its operation and that the purpose of the hotline is to receive complaints or questions about local HHAs. (7-1-93)

x. A patient has the right to be informed of the HHA's right to refuse admission to, or discharge any patient whose environment, refusal of treatment, or other factors prevent the HHA from providing safe care. (7-1-93)

xi. A patient has the right to be informed of all services offered by the agency prior to, or upon admission to the agency. (7-1-93)

xii. A patient has the right to be informed of his condition in order to make decisions regarding his home health care. (7-1-93)

xiii. Upon admission, the HHA provides written and oral information to all adult patients regarding The Natural Death Act (Idaho Code, Title 39, Chapter 45). The agency maintains documentation showing that it has complied with this requirement whether or not the patient has executed an advance directive ("Living Will" and/or "Durable Power of Attorney for Health Care"). (7-1-93)

xiv. An agency cannot condition the provision of care or otherwise discriminate against a patient based

on whether or not the patient has executed an advance directive. (7-1-93)

xv. If the agency cannot comply with the patient's "Living Will" and/or "Durable Power of Attorney for Health Care" as a matter of conscience, the agency will assist the patient in transferring to an agency that can comply. (7-1-93)

xvi. The HHA advises a patient, in advance, of the disciplines that will furnish, care, and frequency of visits proposed to be furnished. (7-1-93)

xvii. The HHA advises a patient in advance of any change in the plan of care before the change is made. (7-1-93)

xviii. A patient has the right to participate in the development of the plan of care, treatment, and discharge planning. The HHA advises the patient in advance of the right to participate in planning the care or treatment. (7-1-93)

xix. A patient has the right to be informed prior to any care provided by the agency which has experimental or research aspects. The patient's or the patient's legal guardian's written consent is required. (7-1-93)

xx. A patient has the right to refuse services or treatment. (7-1-93)

xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: (7-1-93)

(1) The extent to which payment may be expected from third party payors; and (7-1-93)

(2) The charges for services that will not be covered by third party payors; and (7-1-93)

(3) The charges that the patient may have to pay; and (7-1-93)

(4) The HHA informs a patient orally and in writing of any changes in these charges as soon as possible, but no later than thirty (30) days from the date the HHA provider becomes aware of the change. (7-1-93)

xxii. A patient has the right to have access, upon request, to all bills for service he has received regardless of whether they are paid by him or by another party. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

022. DIRECTOR.

01. Qualifications. General supervision, coordination, and direction of the medical, nursing, and other services provided are the responsibility of a physician or licensed registered nurse. The physician or licensed registered nurse or their designee, who must be a physician or licensed registered nurse, must be available at all times during operating hours and must participate in all activities relative to the professional or other services provided, including the qualifications of personnel as related to their assigned duties. (11-19-76)

02. Responsibilities. The director or designee must be responsible for assuring that: (11-19-76)

a. An initial assessment/evaluation is made to provide a data base to plan and initiate care of the patient; (11-19-76)

b. There is a plan of treatment established for each patient; (7-1-93)

c. Continuing assessment and evaluation is provided in accordance with the patient's response and progress as related to the course of his disease or illness and the plan of treatment; (11-19-76)

d. The initial plan of treatment and subsequent changes are approved by signature of the attending ~~*physician*~~ licensed independent practitioner and carried out according to his direction. ~~*(11-19-76)*~~( )

e. The total plan of treatment is reviewed by the attending ~~*physician*~~ licensed independent practitioner as often as the severity of the patient's condition requires and is reviewed at least every sixty (60) days; ~~*(5-3-03)*~~( )

f. Information is available to the attending ~~*physician*~~ licensed independent practitioner on an ongoing basis and is timely, accurate, and significant of change in clinical status or condition; ~~*(11-19-76)*~~( )

g. Information is provided to the administrator and guidance requested as is necessary to carry out assigned duties. (11-19-76)

(BREAK IN CONTINUITY OF SECTIONS)

030. PLAN OF CARE.
Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's plan of care. (7-1-93)

01. Written Plan of Care. A written plan of care must be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: (7-1-93)

a. All pertinent diagnoses; (7-1-93)

b. The patient's mental status; (7-1-93)

c. Types of services and equipment required; (7-1-93)

d. Frequency of visits; (7-1-93)

e. Functional limitations; (7-1-93)

f. Ability to perform basic activities of daily living; (7-1-93)

g. Activities permitted; (7-1-93)

h. Nutritional requirements; (7-1-93)

i. Medication and treatment orders; (7-1-93)

j. Any safety measures to protect against injury; (7-1-93)

k. Any environmental factors that may affect the agency's ability to provide safe, effective care; (7-1-93)

l. The family's or other caregiver's ability to provide care; (7-1-93)

m. The patient and his family's teaching needs; (7-1-93)

n. Planning for discharge; and (7-1-93)

o. Other appropriate items. (7-1-93)

02. Goals of Patient Care. The goals of patient care must be expressed in behavioral terms that

provide measurable indices for performance. (7-1-93)

03. Orders for Therapy Services. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. (7-1-93)

04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a ~~*doctor of medicine, osteopathy, or podiatric medicine*~~ licensed independent practitioner. ~~*(7-1-93)*~~( )

05. Total Plan of Care. The total plan of care is reviewed by the attending ~~*physician*~~ licensed independent practitioner and HHA personnel as often as the severity of the patient's condition requires but at least once every sixty (60) days. ~~*(5-3-03)*~~( )

06. Changes to Plan. Agency professional staff promptly alert the ~~*physician*~~ licensed independent practitioner to any changes that suggest a need to alter the plan of care. ~~*(7-1-93)*~~( )

07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the ~~*physician*~~ licensed independent practitioner. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the ~~*physician*~~ licensed independent practitioner. ~~*(7-1-93)*~~( )

031. CLINICAL RECORDS.

01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. (7-1-93)

02. Contents. Clinical records must include: (7-1-93)

a. Appropriate identifying information; (7-1-93)

b. Assessments by appropriate personnel; (7-1-93)

c. The plan(s) of care; (7-1-93)

d. Name of physician and other providers involved in the patient's care; (3-20-20)

e. Drug, dietary treatment, and activity orders; (7-1-93)

f. Signed and dated clinical and progress notes; (7-1-93)

g. Copies of summary reports sent to the attending physician; (7-1-93)

h. Signed patient release or consent forms where indicated; (11-19-76)

i. A signed dated copy of the patient's bill of rights; (7-1-93)

j. Copies of transfer information sent with the patient; and (7-1-93)

k. A discharge summary. (7-1-93)

03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending ~~*physician*~~ licensed independent practitioner at least every sixty (60) days. ~~*(5-3-03)*~~( )

04. Written Policies and Procedures. Written policies and procedures must ensure that clinical

records are legibly written in ink suitable for photocopying and are available and retrievable during operating hours either in the agency or by electronic means. (7-1-93)

05. Retention Period. Clinical records must be retained for five (5) years after the date of discharge, or in the case of a minor, three (3) years after the patient becomes of age. Policies provide for retention even if the HHA discontinues operations. Records must be protected from damage. (7-1-93)

06. Disposal of Records. There must be a method of disposal of clinical records, assuring prevention of retrieval and subsequent use of information. (7-1-93)

07. Copies of Records. There must be a means of submitting a copy of the clinical record or an abstract and copy of most recent summary report with the patient in the event of patient transfer to another agency or health care facility. (7-1-93)

08. Safeguarding and Protection of the Record. Agencies must ensure that records are protected from unauthorized use and damage and adhere to written procedures governing use and removal of records and conditions for release of information unless authorized by law. (7-1-93)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2002

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Proposed Rule Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2021 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202(b), Idaho Code, and Senate Bill 1204 (2019).

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 made reference to the federal Institutions for Mental Disease (IMD) exclusion, which no longer applies as of the effective date of the approved Medicaid waiver or state plan authority. This rulemaking removes all mentions of this exclusion in rule to allow Medicaid reimbursement for services delivered to eligible adults in an IMD setting. This confers a benefit to citizens needing treatment for substance use disorders and/or mental health disorders in an IMD setting.

The rule changes themselves have been in effect as Temporary rules since January 1, 2020, under the original Temporary Docket No. 16-0309-2001 and repromulgated as a Temporary rule under this docket number effective March 20, 2020 (see Idaho Administrative Bulletin, April 1, 2020, Vol. 20-4, page 40).

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 7, 2020, Idaho Administrative Bulletin, Vol. 20-10, 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:

Senate Bill 1204 (2019) shifted budget dollars from the Division of Behavioral Health to the Division of Medicaid to pay for costs of Medicaid Expansion, including the costs of the sideboards and waivers. Therefore, this rule change will have no net impacts to the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Clay Lord at (208) 364-1979.

Dated this 18th day of November, 2020.

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(b) Idaho Code and Senate Bill 1204 (2019).

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

PUBLIC HEARING

Tuesday, October 20, 2020
3:00 p.m. - 5:00 p.m. MDT

TELECONFERENCE INFORMATION
Call in: 1-877-820-7831
Guest Code: 301388

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

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

This chapter made reference to the federal Institutions for Mental Disease (IMD) exclusion, which no longer applies as of the effective date of the approved Medicaid waiver or state plan authority. This rulemaking removes all mentions of this exclusion in rule to allow Medicaid reimbursement for services delivered to eligible adults in an IMD setting. This confers a benefit to citizens needing treatment for substance use disorders and/or mental health disorders in an IMD setting.

The rule changes themselves have been in effect as Temporary rules since January 1, 2020, under the original Temporary Docket No. 16-0309-2001 and repromulgated as a Temporary rule under this docket number effective March 20, 2020 (see Idaho Administrative Bulletin, April 1, 2020, Vol. 20-4, p. 40).

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: 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:

Senate Bill 1204 (2019) shifted budget dollars from the Division of Behavioral Health to the Division of Medicaid to pay for costs of Medicaid Expansion, including the costs of the sideboards and waivers. Therefore, this rule change will have no net impacts to the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was not feasible. This rulemaking is being done to align with S1204 (2019).

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: 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 28, 2020.

Dated this 14th day of August, 2020.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-2002

701. INPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

01. Inpatient Psychiatric Hospital Services. Participants are eligible who have a diagnosis from the current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in: (7-1-18)

a. A freestanding psychiatric hospital; (7-1-18)

b. A hospital psychiatric unit; and ~~(7-1-18)~~( )

c. Subject to federal approval, an ~~I~~institution~~s~~ for mental disease~~s~~. ~~for participants meeting the conditions in Subsections 701.01.c.i. and 701.01.c.ii. of this rule:~~ ~~(7-1-18)~~( )

~~i. Participants must be under the age of twenty-one (21); and (7-1-18)~~

~~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. (7-1-18)~~

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:~~ ~~(7-1-18)~~( )

~~a. A freestanding psychiatric hospital; or (7-1-18)~~

~~b. A hospital psychiatric unit. (7-1-18)~~

03. Severity of Illness Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. (7-1-18)

a. Severity of illness criteria. The participant must meet one (1) of the following criteria related to the severity of ~~his~~ their psychiatric illness: ~~(7-1-18)~~( )

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~~ their 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 participant or a reliable source and details of the participant's plan must be documented); or (7-1-18)

(4) The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk of making an attempt without immediate intervention; or (7-1-18)

ii. Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms ~~*which*~~ that indicate they ~~*is*~~ are a probable danger to others as indicated by one (1) of the following: ~~*(7-1-18)*~~( )

(1) The participant has engaged in, or threatened, behavior harmful or potentially harmful to others or caused serious damage to property ~~*which*~~ that would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or ~~*(7-1-18)*~~( )

(2) The participant has made threats to kill or seriously injure others or to cause serious damage to property ~~*which*~~ that would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or ~~*(7-1-18)*~~( )

(3) A mental health professional has information from the participant or a reliable source that the participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or (7-1-18)

iii. Participant is gravely impaired as indicated by at least one (1) of the following criteria: (7-1-18)

(1) The participant has such limited functioning that ~~*his*~~ their physical safety and well being are in jeopardy due to ~~*his*~~ their inability for basic self-care, judgment, and decision making (details of the functional limitations must be documented); or ~~*(7-1-18)*~~( )

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the participant unmanageable and unable to cooperate in non-hospital treatment (details of the participant's behaviors must be documented); or (7-1-18)

(3) There is a need for treatment, evaluation, or complex diagnostic testing where the participant's level of functioning or communication precludes assessment ~~*and/*~~or treatment, or both, in a non-hospital based setting, and may require close supervision of medication or behavior or both. ~~*(7-1-18)*~~( )

(4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. (7-1-18)

04. Intensity of Service Criteria. The participant must meet all of the following criteria related to the intensity of services needed for treatment. (7-1-18)

a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and (7-1-18)

b. The services provided can reasonably be expected to improve the participant's condition or prevent further regression so that inpatient services will no longer be needed; and (7-1-18)

c. Treatment of the participant's condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation. (7-1-18)

d. Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the participant is in ~~*his*~~ their current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. ~~*(7-1-18)*~~( )

05. Exclusions. If a participant meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: (7-1-18)

a. The participant is unable to actively participate in an outpatient treatment program solely because of a major medical condition, surgical illness or injury; or (7-1-18)

b. The participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability. (7-1-18)

702. INPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Initial Length of Stay. An initial length of stay, or a prior authorization requirement, will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will never be more restrictive than requirements for non-behavioral health services in a general hospital. (7-1-18)

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for inpatient days in excess of the initial length of stay or previously approved extended stay. (7-1-18)

~~***03. Excluded Services**. Placement in an IMD for participants between the ages of twenty-one (21) and sixty-four (64) is not a covered service.* *(7-1-18)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2004

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Proposed Rule Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2021 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202(b) and the 21st Century Cures Act – Public Law 114–255, Section 12006.

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 contains rule changes in two (2) subject areas -- (1) Peer Support and Recovery Coaching and (2) Electronic Visit Verification (EVV). Changes for (1) allow the Department to waive clearance requirements for those providing peer support and recovery coaching, which in turn would expand access to these services. Changes for (2) secure State authority for the implementation of an Electronic Visit Verification (EVV) system to comply with the 21st Century Cures Act while helping minimize provider administrative burden.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2020, Idaho Administrative Bulletin, Vol. 20-10, pages 42 through 50.

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:

For Peer Support and Recovery Coaching: there are no fiscal impacts to the State General Fund (SGF) expected if the changes are implemented, since the services are currently available to any Medicaid participant who needs them. By increasing the size of the provider pool, the change is intended to decrease the number of days Medicaid participants must wait to book appointments with providers. Decreasing delays in the onset of treatment is critical to the success of Idaho's response to the opioid crisis.

For EVV: Senate Bill 1418 (2020) approved EVV implementation costs that include a one-time system expense of $545,700 from the SGF for SFY 2020. This cost is the combined shared sum with the EVV implementation for Docket No. 16-0310-2002 implementing EVV for Personal Care Services (PCS) and Aged and Disabled (A&D) waiver services. In order to minimize financial impact to SGF, the Department chose to do the minimum system implementation by amending the contract with our current MMIS contractor (DXC Technologies) to add an MMIS Aggregator for EVV and provide training and validation for providers that must comply with EVV requirements. Providers are allowed the choice of the EVV Solution that meets their agency's budget and process needs, as long as it is verified as compatible by the MMIS subcontractor in charge of the EVV work. Ongoing support and maintenance related to EVV systems will include a monthly fee, but this is incorporated in the annually approved MMIS Contract and not expected to add to an additional line item for future budget years. In the Department budget approved during the 2020 Legislative Session, the total breakdown for EVV service implementation (under this docket and Docket No. 16-0310-2002) is as follows: State General Fund Allocation: $545,700, Federal Fund Allocation: $1,828,700, and Total Allocation: $2,374,400.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jennifer Pinkerton (208) 287-1171.

Dated this 18th day of November, 2020.

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(b) and the 21st Century Cures Act – Public Law 114–255, Section 12006.

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

PUBLIC HEARINGS

For Electronic Visit Verification (EVV) --
Wednesday, October 14, 2020, 3:00 p.m. - 5:00 p.m. MDT

WebEx INFORMATION
WebEx Phone:
+1-415-655-0003 US Toll
+1-720-650-7664 United States Toll
Meeting Number (Access Code): 133 127 0087
Meeting password: medicaidhearing (63342243 from phones and video systems)
WebEx Link:
https://idhw.webex.com/idhw/j.php?MTID=m552a7147cb81abe347c3ac20a559c64c

For Waiver of Criminal History Check for Peer Support/Recovery Coaching --
Tuesday, October 20, 2020, 3:00 p.m. - 5:00 p.m. MDT

TELECONFERENCE INFORMATION
Call in: 1-877-820-7831
Guest Code: 301388

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:

1. Peer Support and Recovering Coaching: There is an ongoing issue with the availability of Peer Support and Recovery Coaching services delivered through the Idaho Behavioral Health Plan (IBHP). Qualified providers of these services have lived experience with substance use disorders; however, prospective providers who are recovering addicts frequently have drug convictions on their criminal records, and therefore cannot obtain criminal history check clearance. This change would allow the Department to waive clearance requirements for these providers, which in turn would expand access to these services.

2. Electronic Visit Verification (EVV): These rule changes secure State authority to implementation of an Electronic Visit Verification (EVV) system to comply with the 21st Century Cures Act while helping minimize provider administrative burden. EVV Implementation aims to protect participants by verifying services are received using an electronic verification method, and also aims to reduce instances of fraud, waste, and abuse by providers who bill for these services. Medicaid is in the process of implementing an Open Model structure for providers, allowing providers freedom to choose the EVV provider that best fits with each agency's budget and needs as long as it is certified as compatible with the Data Aggregator DXC Technology (Medicaid's existing Medicaid Management Information System vendor) will launch to process EVV claims. DXC will also include provider training and certification to help the implementation process. Rulemaking will be as minimal as possible, to ensure CMS compliance with the Act, while procedural guidance will be provided via Idaho Provider Handbook and DXC training materials.

The Department also intends to take this opportunity to simplify existing procedural requirements in rule related to Home Health services that correspond to EVV implementation.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: 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:

For Peer support and recovery coaching: there are no fiscal impacts to the State General Fund expected if the changes are implemented, since the services are currently available to any Medicaid participant who needs them. By increasing the size of the provider pool, the change is intended to decrease the number of days Medicaid participants must wait to book appointments with providers. Decreasing delays in the onset of treatment is critical to the success of Idaho's response to the opioid crisis.

For EVV: Senate Bill 1418 (2020) approved EVV implementation costs that include a one-time system expense of $545,700 from the SGF for SFY 2020. This cost is the combined shared sum with the EVV implementation for Docket No. 16-0310-2002 implementing EVV for Personal Care Services (PCS) and Aged and Disabled (A&D) waiver services. In order to minimize financial impact to SGF, the Department chose to do the minimum system implementation by amending the contract with our current MMIS contractor (DXC Technologies) to add an MMIS Aggregator for EVV and provide training and validation for providers that must comply with EVV requirements. Providers are allowed the choice of the EVV Solution that meets their agency's budget and process needs, as long as it is verified as compatible by the MMIS subcontractor in charge of the EVV work. Ongoing support and maintenance related to EVV systems will include a monthly fee, but this is incorporated in the annually approved MMIS Contract and not expected to add to an additional line item for future budget years. In the Department budget approved during the 2020 Legislative Session, the total breakdown for EVV service implementation (under this docket and Docket No. 16-0310-2002) is as follows: State General Fund Allocation: $545,700, Federal Fund Allocation: $1,828,700, and Total Allocation: $2,374,400.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because negotiated rulemaking was not feasible. However, extensive informal negotiated rulemaking was conducted with stakeholders in 2019 and 2020.

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: For assistance on technical questions concerning the proposed rule, contact Jennifer Pinkerton (208) 287-1171.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2020.

Dated this 14th day of August, 2020.

Red italicized double underscored text **indicates amendments between the proposed and pending rule.**

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-2004

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." (3-30-07)

02. Department-Issued Variances to Requirements for a Criminal History Check Clearance. ( )

a. Notwithstanding those provider types required to obtain a criminal history check clearance or Department enhanced clearance under these rules or under IDAPA 16.05.06, "Criminal History and Background Checks," the Department at its discretion may allow variances to clearance requirements under certain circumstances. Providers who are subject to a criminal history and background check must still complete and notarize an application for a criminal history and background check. ( )

b. In cases where the application process results in a denial rather than a clearance, and the denial is due to the applicant's prior convictions for disqualifying drug and alcohol-*related* offenses, the applicant may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services. ( )

c. A variance may be granted on a case-by-case basis upon review by the Department or its designee of any underlying facts and circumstances in each individual case. The Department will establish the process for the administrative review which will be conducted separate from the criminal history unit. During the Department's review, the following factors may be considered: ( )

i. The severity or nature of the crimes or other findings; ( )

ii. The period of time since the incidents occurred; ( )

iii. The number and pattern of incidents being reviewed; ( )

iv. Circumstances surrounding the incidents that would help determine the risk of repetition; ( )

v. The relationship between the incidents and the position sought; ( )

vi. Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation; ( )

vii. A pardon that was granted by *a state g*overnor or the President of the United States; ( )

viii. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and ( )

ix. Any other factor deemed relevant to the review. ( )

d. A variance granted under these rules is not a criminal history and background check clearance and does not set a precedent for subsequent application for variance. The Department may revoke a variance when it identifies a risk to participants' health and safety. Providers who have been granted a variance must still meet all other Department requirements for Medicaid coverage and reimbursement of Peer Support and Recovery Coaching services, and are prohibited from delivering any other covered Medicaid service without the required clearance or Department enhanced clearance. ( )

0~~2~~3. Availability to Work or Provide Service. (3-30-07)

a. The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. (3-30-07)

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. (3-30-07)

0~~3~~4. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-30-07)

0~~4~~5. Providers Subject to Criminal History Check Requirements. The following providers must receive a criminal history clearance: (3-30-07)

a. Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of individual contracted transportation providers defined in Subsection 870.02 of these rules. (4-7-11)

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules must consent to comply with criminal background checks, including fingerprinting, in accordance with 42 CFR 455.434. (3-20-14)

(BREAK IN CONTINUITY OF SECTIONS)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a

complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-20-14)

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-30-07)

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and (3-30-07)

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification. (3-20-14)

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-30-07)

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-20-14)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-30-07)

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-30-07)

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-30-07)

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-20-14)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid eligible individuals and providers as specified in Section 563 of these rules. (3-25-16)

09. Services Delivered Via Telehealth. Services delivered via telehealth as defined in Title 54, Chapter 57, Idaho Code, must be identified as such in accordance with billing requirements published in the Idaho Medicaid Provider Handbook. Telehealth services billed without being identified as such are not covered. Services delivered via telehealth may be reimbursed within limitations defined by the Department in the Idaho Medicaid

Provider Handbook. Fee for service reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a physician and a participant. (3-25-16)

10. Services Subject to Electronic Visit Verification (EVV). Services requiring EVV compliance are subject to quality review. Services billed without the minimum essential *EVV* elements, as defined by Section 1903(l)(2) of the Social Security Act, may be denied, delayed, or subject to sanctions or recoupment, or both, in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

(BREAK IN CONTINUITY OF SECTIONS)

720. HOME HEALTH SERVICES: DEFINITIONS.

01. Aggregator. System that collects provider EVV information from multiple software platforms and standardizes the information in MMIS for EVV data validation. ( )

02. Claims Adjudication. The process of determining Medicaid financial responsibility for claims submitted to MMIS. ( )

03. Electronic Visit Verification (EVV). EVV is a software or device(s) that electronically captures information verifying services delivered in a participant's home. ( )

0~~1~~4. Home Health Plan of Care. A written description of home health services to be provided to a participant as defined in IDAPA 16.03.07, "Home Health Agencies." ~~(7-1-17)~~( )

0~~2~~5. Home Health Services. Home health services ~~*are services*~~ and items~~,~~ includ~~*ing*~~e nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, audiology services, and medical supplies, equipment, and appliances ~~*that are:*~~ provided under a home health plan of care. ~~(7-1-17)~~( )

~~***a.** Ordered by a physician as part of a home health plan of care; (7-1-17)*~~

~~***b.** Performed by a licensed, qualified professional acting within their authorized scope of practice; (7-1-17)*~~

~~***c.** Typically received by a participant at the participant's place of residence, but may be received in any setting in which normal life activities take place, other than a hospital, nursing facility, ICF/ID (unless such services are not otherwise required to be provided by the ICF/ID), or any other setting in which payment is made, or could be made, under Medicaid for inpatient services that include room and board; and (7-1-17)*~~

~~***d.** Reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-17)*~~

~~***03. Place of Residence**. For the purposes of home health services, generally any setting in which a participant makes their home, other than a hospital, nursing facility, or ICF/ID. (7-1-17)*~~

721. (RESERVED)

722. HOME HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Settings. Home health services are covered in a participant's place of residence and any setting in which normal life activities take place. Services are not covered when provided in a: ( )

a. Hospital; ( )

b. Nursing facility; ( )

c. ICF/IID, unless such services are not otherwise required to be provided by the ICF/IID; or ( )

d. Any setting in which Medicaid covers inpatient services, including room and board. ( )

02. Limitations. Home health ~~visits~~ services are limited to one hundred (100) visits per calendar year per person. ~~(3-30-07)~~( )

03. Requirements. Services and items must be medically necessary and when appropriate, meet the requirements for: ( )

a. Audiology services under Sections 740 through 749 of these rules; ( )

b. Medical supplies, items, and appliances under Sections 750 through 779 of these rules; ( )

c. Physical therapy, occupational therapy, and speech-language pathology services under Sections 730 through 739 of these rules; and ( )

d. Early Periodic, Screening, Diagnosis, and Treatment Services under Sections 880 through 889 of these rules. ( )

723. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. ~~Physician~~ Orders. ~~(7-1-17)~~( )

a. Home health services must be ordered by a physician, nurse midwife, nurse practitioner, clinical nurse specialist, or physician assistant. ~~Such o~~Orders must include at a minimum, the ~~physician's~~ provider's National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. Orders for medical supplies, equipment, and appliances are detailed in Section 753 of these rules. ~~(7-1-17)~~( )

b. ~~In the event that h~~Home health services ~~are~~ required for extended periods~~, these services~~ must be reordered ~~as necessary, but~~ at least every sixty (60) days for services and ~~at least~~ annually for medical supplies, equipment, and appliances. ~~(7-1-17)~~( )

02. Face-to-Face Encounter for Home Health Services, ~~Excluding~~ Medical Supplies, Equipment, and Appliances. ~~(7-1-17)~~( )

a. ~~For the initiation of~~ To initiate home health services, ~~excluding~~ medical supplies, equipment, and appliances, the participant's physician, or a non-physician practitioner as authorized in this rule, must document ~~that~~ a face-to-face encounter ~~that is~~ related to the primary reason the patient requires home health services. ~~occurred with the participant no more than ninety (90) days before, or thirty (30) days after, the start of the home health services. Appropriate d~~Documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. ~~(7-1-17)~~( )

i. For home health services, the face-to-face encounter must have occurred no more than ninety (90) days before, or thirty (30) days after, the start of the home health services. ( )

ii. For home health medical supplies, equipment, and appliances, the face-to-face encounter must have occurred no more than six (6) months before the start of services. ( )

b. The face-to-face encounter may occur via telehealth, as defined in ~~Title 54, Chapter 57, Idaho Code~~ Subsection 210.09 of these rules. ~~(7-1-17)~~( )

c. The face-to-face encounter may be performed by ~~participant's physician, including an attending acute or post-acute physician, or one (1) of the following non-physician practitioners (NPP)~~: ~~(7-1-17)~~( )

i. The participant's physician, including an attending acute or post-acute physician; ( )

ii. A nurse practitioner or clinical nurse specialist ~~working in collaboration with the ordering physician~~; ~~(7-1-17)~~( )

iii. A nurse midwife; or (7-1-17)

~~ii~~iv. A physician assistant ~~under the supervision of the ordering physician~~. ~~(7-1-17)~~( )

~~**d.** *If the face-to-face encounter is performed by an allowed NPP, the NPP must communicate the clinical findings of that face to face encounter to the ordering physician.* (7-1-17)~~

~~***03. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances.*** (7-1-17)~~

~~**a.** *For the initiation of home health medical supplies, equipment, and appliances, the participant's physician, or a non-physician practitioner as authorized in Subsection 723.03 of this rule, must document that a face-to-face encounter that is related to the primary reason the patient requires medical supplies, equipment, and appliances, occurred with the participant no more than six (6) months before the start of services. Appropriate documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual.* (7-1-17)~~

~~**b.** *The face-to-face encounter may occur via telehealth, as defined in Title 54, Chapter 57, Idaho Code.* (7-1-17)~~

~~**c.** *The face-to-face encounter may be performed by participant's physician, including an attending acute or post-acute physician, or one (1) of the following non-physician practitioners (NPP):* (7-1-17)~~

~~i. *A nurse practitioner or clinical nurse specialist working in collaboration with the ordering physician; or* (7-1-17)~~

~~ii. *A physician assistant under the supervision of the ordering physician.* (7-1-17)~~

~~**d.** *If the face-to-face encounter is performed by an allowed NPP, the NPP must communicate the clinical findings of that face-to-face encounter to the ordering physician.* (7-1-17)~~

0~~4~~3. **Home Health Plan of Care**. (7-1-17)

a. All home health services must be provided under a home health plan of care that is established prior to beginning treatment. ~~*The home health plan of care*~~ and must be signed by the licensed, qualified professional who established the plan ~~*and must contain the information required under IDAPA 16.03.07, "Home Health Agencies."*~~ ~~(7-1-17)~~( )

b. All home health plans of care must be reviewed by the ~~*participant's physician as necessary, but*~~ ordering provider at least every sixty (60) days for services, and ~~*at least*~~ annually for medical supplies, equipment, and appliances. ~~(7-1-17)~~( )

724. ELECTRONIC VISIT VERIFICATION (EVV).
Effective July 1, 2021, Home Health Agencies (HHA) are required to submit claims using a compliant EVV system as mandated by Section 12006 of the 21st Century Cures Act for all services provided in the participant's residence, except for the provision of medical supplies and equipment. Providers must: ( )

01. Maintain System. Maintain an EVV system chosen by their agency that is certified as compliant with the MMIS aggregator, as determined by the Department and/or the MMIS Contractor; ( )

02. Document Consent. Document and retain participant consent for use of *electronic* verification methods; *( )*

03. Develop Policies and Procedures. Develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for safeguarding of participant information and privacy; and ( )

04. Submit EVV Data. Submit EVV data that captures these six (6) system-validated data elements for services delivered in the participant's home: ( )

a. Date of service; ( )

b. Time the service begins and ends; ( )

c. Individual providing the service; ( )

d. Participant receiving the service; ( )

e. *Billable* service performed; and ( )

f. Location of service delivery. ( )

724~~4~~5. HOME HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
In order to participate as a Home Health Agency (HHA) provider for Medicaid-eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification is cause for termination of Medicaid provider status. (3-30-07)

725~~5~~6. HOME HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. ~~*Mileage Included in Cost*~~. ~~*Payment by the Department for home health services will include mileage as part of the cost of the visit.*~~ ~~*(3-30-07)*~~

~~***02.***~~ ~~***Payment Procedures***~~ **Home Health Services**. Payment for home health services ~~*will be*~~ is limited to the services authorized in Sections 720 through 722 of these rules and must not exceed the lesser of reasonable cost as determined by Medicare or the Medicaid percentile cap. ~~*(3-30-07)*~~( )

a. ~~*For visits performed in the first state fiscal year for which this Subsection is in effect, the Medicaid percentile cap will be established at the seventy fifth percentile of the ranked costs per visit as determined by the Department using the data from the most recent finalized Medicare cost reports on hand in the Department on June 1, 1987. Thereafter, the*~~ The Medicaid percentile cap ~~*will be*~~ is revised annually, effective at the beginning of each state fiscal year. Revisions ~~*will be*~~ are made using the data from the most recent finalized Medicare cost reports on hand thirty (30) days prior to the effective date. ~~*(3-30-07)*~~( )

b. ~~*When determining reasonable costs of rented medical equipment ordered by a physician and used for the care of the participant, the total rental cost of a Durable Medical Equipment (DME) item must not exceed one-tenth (1/10) of the total purchase price of the item. A minimum rental rate of fifteen dollars ($15) per month is allowed on all DME items*~~Payment by the Department for home health will include mileage as part of the cost of the visit. ~~*(7-1-17)*~~( )

c. ~~*The Department may enter into lease/purchase agreements with providers in order to purchase medical equipment when the rental charges total the purchase price of the equipment*~~Provider claims for services requiring EVV will include the corresponding EVV data elements listed in Subsection 724.04 of these rules. Provider EVV data will be submitted to the state's aggregator prior to billing claims. Claims corresponding to EVV data submissions are subject to a quality review in accordance with Subsection 210.10 of these rules. ~~*(3-30-07)*~~( )

d. ~~*The Department will not pay for services at a cost in excess of prevailing Medicare rates.(3-30-07)*~~

~~***c.***~~ If a person is eligible for Medicare, all services ordered by the physician will be purchased by Medicare, except for the deductible and co-insurance amounts that the Department will pay. (3-30-07)

02. Medical Supplies, Equipment, and Appliances. Payment for medical supplies, equipment, and appliances is detailed in Section 755 of these rules. ( )

726~~6~~7. -- 729. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-2002

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Proposed Rule Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2021 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202(b) and the 21st Century Cures Act – Public Law 114–255, Section 12006.

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 contains rule changes in two (2) subject areas -- (1) Electronic Visit Verification (EVV) - Personal Care Services (PCS), and (2) Behavioral Care Units (BCU). Changes for (1) are being done by the Department to secure state authority allowing implementation of an Electronic Visit Verification (EVV) system to comply with Section 12006 of the 21st Century Cures Act (Public Law 114–255) while helping minimize provider administrative burden. The Cures Act mandates states to implement an Electronic Visit Verification (EVV) system for all Personal Care Services (PCS) that require an in-home visit by a provider.

Changes for (2) increase the current Behavioral Care Unit (BCU) census requirement from 20% to 30% for new BCU providers. This increase will help the Department maintain support for BCU providers consistent with state needs and aligns this chapter with HB351 (2020) requirements for nursing facilities. Other changes are planned for 2021 to complete the alignment of this chapter with the requirements of this new statute. There are NO additional changes from the Proposed language published in October.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 7, 2020, Idaho Administrative Bulletin, Vol. 20-10, pages 51 through 77.

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:

EVV - PCS -- S1418 (2020) approved costs that include a one-time system implementation expense of $545,700 from the State General Fund (SGF) for SFY2020. This cost is shared with expenses shown with the companion docket for 16.03.09 Medicaid Basic Plan Benefits for EVV Home Health services. To minimize fiscal impact to the SGF, the Department chose to pursue the minimum system implementation by amending the contract with our current MMIS contractor (DXC Technologies) to add an MMIS Aggregator for EVV and provide training and validation for providers that must comply with EVV requirements. Providers are allowed the choice of the EVV Solution that meets their agency's budget and process needs, if it is verified as compatible by the MMIS subcontractor in charge of the EVV work. A rate increase was approved, and this was for PCS and related A&D Waiver Services totaling $1,589,000 of the combined budget allocation. These rate increases went into effect on July 1, 2020. Ongoing support and maintenance related to EVV systems include a monthly fee, that is incorporated in the annually approved MMIS Contract and is not expected to add to an additional line item for the future.

BCU -- Budgets for nursing facilities will remain the same. There is no anticipated fiscal impact to state or general funds as a result of this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, for EVV-PCS contact Jennifer Pinkerton at (208) 287-1171; for BCU contact Alex Childers-Scott at (208) 364-1891.

Dated this 18th day of November, 2020.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5500
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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(b) and the 21st Century Cures Act – Public Law 114–255, Section 12006.

PUBLIC HEARING SCHEDULES: Public hearings concerning this rulemaking will be held as follows. ONE (1) is for Electronic Visit Verification – Personal Care Services and TWO (2) is for Behavioral Care Units:

PUBLIC HEARINGS

For Electronic Visit Verification (EVV) --
Wednesday, October 14, 2020, 3:00 p.m. - 5:00 p.m. MDT

WebEx INFORMATION
WebEx Phone:
+1-415-655-0003 US Toll
+1-720-650-7664 United States Toll
Meeting Number (Access Code): 133 127 0087
Meeting password: medicaidhearing (63342243 from phones and video systems)
WebEx Link:
https://idhw.webex.com/idhw/j.php?MTID=m552a7147cb81abe347c3ac20a559c64c

For Behavioral Care Units --
Friday, October 16, 2020, 1:00 p.m. - 2:00 p.m. MDT

WebEx INFORMATION
WebEx Phone:
+1-415-655-0003 US Toll
+1-720-650-7664 United States Toll
Meeting Number (Access Code): 133 091 2789
Meeting password: 9wpq64v5xm9 (99776485 from phones and video systems)
WebEx Link:
https://idhw.webex.com/idhw/j.php?MTID=mccf4fd75ab5d64ae832315a5595029ac

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:

ELECTRONIC VISIT VERIFICATION (EVV) - PERSONAL CARE SERVICES (PCS) and Aged and Disabled (A&D) Waiver Services -- All Sections EXCEPT for 267 and 268 -- This rulemaking is being done by the Department to secure state authority allowing implementation of an Electronic Visit Verification (EVV) system to comply with Section 12006 of the 21st Century Cures Act (Public Law 114–255) while helping minimize provider administrative burden. The Cures Act mandates states to implement an Electronic Visit Verification (EVV) system for all Personal Care Services (PCS) and Aged and Disabled (A&D) Waiver Services that require an in-home visit by a provider.

EVV Implementation aims to protect participants by verifying services are received using an electronic verification method (phone, GPS, etc.), and also aims to reduce instances of fraud, waste, and abuse by providers who bill for these services. Medicaid is in the process of implementing an Open Model structure for providers, allowing providers freedom to choose the EVV provider that best fits with each agency's budget and needs as long as it is certified as compatible with the Data Aggregator DXC Technology (Medicaid's existing Medicaid Management Information System vendor) will launch to process EVV claims. DXC will also include provider training and certification to help the implementation process. Rulemaking will be as minimal as possible, to ensure CMS compliance with the Act, while procedural guidance will be provided via Idaho Provider Handbook and DXC training materials.

The Department is also simplifying existing procedural requirements in rule related to Home Health services that correspond to EVV implementation.

BEHAVIORAL CARE UNITS (BCU) -- ONLY Sections 267 and 268 -- The Department, providers, and the Idaho Health Care Association have agreed to increase the current Behavioral Care Unit (BCU) census requirement from 20% to 30% for new BCU providers. This increase will help the Department maintain support for BCU providers consistent with state needs and aligns this chapter with HB351 (2020) requirements for nursing facilities. The changes contained in this rulemaking are the first stage of those required to comply with the aforementioned legislation. These changes were requested by stakeholders to be put into rule as soon as possible. Other changes are planned for 2021 to complete the alignment of this chapter with the requirements of this new statute.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein: N/A for EVV-PCS and BCU.

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:

EVV - PCS and A&D -- S1418 (2020) approved costs that include a one-time system implementation expense of $545,700 from the SGF for SFY2020. This cost is shared with expenses shown with the companion docket for 16.03.09 Medicaid Basic Plan Benefits for EVV Home Health services. To minimize fiscal impact to SGF, the Department chose to pursue the minimum system implementation by amending the contract with our current MMIS contractor (DXC Technologies) to add an MMIS Aggregator for EVV and provide training and validation for providers that must comply with EVV requirements. Providers are allowed the choice of the EVV Solution that meets their agency's budget and process needs, if it is verified as compatible by the MMIS subcontractor in charge of the EVV work. A rate increase was approved, and this was for PCS and related A&D Waiver Services totaling $1,589,000 of the combined budget allocation. These rate increases went into effect on July 1, 2020. Ongoing support and maintenance related to EVV systems include a monthly fee, that is incorporated in the annually approved MMIS Contract and is not expected to add to an additional line item for the future.

BCU -- Budgets for nursing facilities will remain the same. There is no anticipated fiscal impact to state or general funds as a result of this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because negotiated rulemaking was not feasible. However, for both **EVV - PCS** and **BCU** - extensive informal negotiated rulemaking was conducted with stakeholders in 2019 and 2020.

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: For assistance on technical questions concerning the proposed rule, for **EVV - PCS** contact Jennifer Pinkerton (208) 287-1171; for **BCU** contact Angela Toomey at (208) 364-1817.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2020.

Dated this 14th day of August, 2020.

Red italicized double underscored text **indicates amendments between the proposed and pending rule.**

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-2002

041. SPECIALIZED REIMBURSEMENT: ELECTRONIC VISIT VERIFICATION (EVV).

01. Services Subject to EVV Requirement. Effective July 1, 2021, providers of the following services are required to submit claims using a compliant EVV system as mandated by Section 12006 of the 21st Century Cures Act for services provided in a participant's residence: ( )

a. Private Duty Nursing Services as described in Sections 200 through 210 of these rules; ( )

b. Personal Care Services (PCS) as described in Sections 300 through 309 of these rules; ( )

c. The following Aged and Disabled Waiver Services as described in Sections 320 through 329 of these rules: ( )

i. Attendant Care; ( )

ii. Homemaker; and ( )

iii. Respite. ( )

02. EVV Definitions. ( )

a. Aggregator. System that collects provider EVV information from multiple software platforms and standardizes the information in MMIS for EVV data validation. ( )

b. Claims Adjudication. The process of determining Medicaid financial responsibility for claims submitted to MMIS. ( )

c. Electronic Visit Verification (EVV). EVV is software or device(s) that electronically captures information verifying services delivered in a participant's home. ( )

03. Claims Subject to EVV Requirements. To submit eligible claims for services with EVV requirements, providers must: ( )

a. Maintain an EVV system chosen by their agency and certified as compliant with the MMIS aggregator, as determined by the Department and/or the MMIS Contractor; ( )

b. Document and retain participant consent for use of *electronic* verification methods; ( )

c. Develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for safeguarding of participant information and privacy; and ( )

d. Submit EVV data that captures these six (6) system-validated data elements for services delivered in the Participant's home: ( )

i. Date of service; ( )

ii. Time the service begins and ends; ( )

iii. Individual providing the service; ( )

iv. Participant receiving the service; ( )

v. *Billable* service performed; and ( )

vi. Location of service delivery. ( )

e. Provider claims for services requiring EVV will include the corresponding EVV data elements listed above. Provider EVV data will be submitted to the state's aggregator prior to billing claims. These claims are subject to a quality review in accordance with Subsection 210.10 of IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

04~~1~~2. -- 049. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

202. PRIVATE DUTY NURSING: ELIGIBILITY.
To be eligible for ~~*Private Duty Nursing (*~~PDN~~)~~, the nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or policy require the service to be provided by an Idaho Licensed Registered Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services. PDN service will be authorized by the Department prior to delivery of

service. ~~*(3-19-07)*~~( )

203. PRIVATE DUTY NURSING: FACTORS ASSESSED FOR ELIGIBILITY AND REDETERMINATION.
Factors assessed for eligibility/redetermination include: (3-19-07)

01. Age for Eligibility. The individual is under the age of twenty-one (21) years. (3-19-07)

02. Maintained in Personal Residence. That the child is ~~*being*~~ maintained in their personal residence and receives safe and effective services through PDN services. ~~*(3-19-07)*~~( )

03. Medical Justification. The child receiving PDN services has medical justification and physician's orders. (3-19-07)

04. Written Plan of Care. That there is an updated written plan of care signed by the attending physician, the parent or legal guardian, PDN, RN supervisor, and a representative from the Department. (3-19-07)

05. Attending Physician. That the attending physician has determined the number of PDN hours needed to ensure the health and safety of the child in their home. (3-19-07)

06. Redetermination. Redetermination will be at least annually. The purpose of an annual redetermination for PDN is to: (3-19-07)

a. Determine if the child continues to meet the PDN criteria in Subsection 203.01 through 203.05 of these rules; and (3-19-07)

b. Assure that services and care are medically necessary and appropriate. (3-19-07)

204. PRIVATE DUTY NURSING: COVERAGE AND LIMITATIONS.
PDN services are functions that cannot be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

01. Ordered by a Physician. PDN Services must be ordered by a physician and include: (3-19-07)

a. A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medications or other interventions; or (3-19-07)

b. An assessment by a licensed registered nurse of a child's health status for unstable chronic conditions that includes an evaluation of the child's responses to interventions or medications. (3-19-07)

02. Plan of Care. PDN Services ~~*must include*~~ require a Plan of Care that: ~~*(3-20-20)*~~( )

a. Is developed by a multi-disciplinary team to include, at a minimum, the parent or legal guardian, the primary PDN, RN, or RN Supervisor, and a representative from the Department; (3-19-07)

b. Includes all aspects of the medical, licensed, and personal care services medically necessary to be performed, including the amount, type, and frequency of such service; (3-19-07)

c. Is approved and signed by the attending physician, parent or legal guardian, and primary PDN, RN, or RN supervisor, and a representative from the Department; and (3-19-07)

d. Is revised and updated as child's needs change or upon significant change of condition, but at least annually, and is submitted to the Department for review and prior authorization of service. (3-19-07)

03. Status Updates. Status updates must be completed every ninety (90) days from the start of services. The Status Update is intended to document any change in the child's health status. Annual plan reviews will

replace the fourth quarter Status Update. The Status Update must be signed by both the parent or legal guardian and the primary RN supervisor completing the form. (3-19-07)

04. Limitations. PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: (3-19-07)

a. Licensed Nursing Facilities (NF); (3-19-07)

b. Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID); (3-19-07)

c. Residential Assisted Living Facilities; (3-20-20)

d. Licensed hospitals; and (3-19-07)

e. Public or private school. (3-19-07)

205. – 208. (RESERVED)

209. PRIVATE DUTY NURSING: PROVIDER QUALIFICATIONS AND DUTIES.

01. Primary RN Responsibility For PDN Redetermination. Primary RN responsibility for PDN redetermination is to submit a current plan of care to the Department at least annually or as the child's needs change. Failure to submit an updated plan of care to the Department prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN services. The plan of care must include all requested material outlined in Subsection 204.02 of these rules. (3-19-07)

02. Physician Responsibilities. Physician responsibilities include: (3-19-07)

a. Medical Information. Provide the Department the necessary medical information in order to establish the child's medical eligibility for services based on an EPSDT screen. (3-19-07)

b. Order Services. Order all services to be delivered by the private duty nurse. (3-19-07)

c. Sign Medical Plan of Care. Review, sign, and date child's Medical Plan of Care and orders at least annually or as condition changes. (3-19-07)

d. Community Resources. Determine if the combination of PDN Services along with other community resources are sufficient to ensure the health or safety of the child. If it is determined that the resources are not sufficient to ensure the health and safety of the child, notify the family and the Department and facilitate the admission of the child to the appropriate medical facility. (3-19-07)

03. Private Duty Nurse Responsibilities. RN supervisor or an RN providing PDN services responsibilities include: (3-19-07)

a. Notify the physician immediately of any significant changes in the child's medical condition or response to the service delivery; (3-19-07)

b. Notify the Department within forty-eight (48) hours or on the first business day following a weekend or holiday of any significant changes in the child's condition or if the child is hospitalized at any time; (3-19-07)

c. Evaluate changes of condition; (3-19-07)

d. Provide services in accordance with the nursing care plan; and (3-19-07)

e. Must ensure copies of records are maintained in the child's home including: (3-20-20)

i. The date; (3-19-07)

ii. Time of start and end of service delivery each day; (3-19-07)

iii. Comments on child's response to services delivered; (3-19-07)

iv. Nursing assessment of child's status and any changes in that status per each working shift; (3-19-07)

v. Services provided during each working shift; and (3-19-07)

vi. The Medical Plan of Care signed by the physician, primary RN, the parent or legal guardian and a representative from the Department. (3-19-07)

04. LPN Providers. ~~*In the case of*~~ LPN providers, document that oversight of services by an RN is in accordance with the Idaho Nursing Practice Act and IDAPA 23.01.01, "Rules of the Board of Nursing." RN Supervisor visits must occur at least once every thirty (30) days when services are provided by an LPN. ~~*(3-19-07)*~~( )

05. Ensure Health and Safety of Children. PDN providers must notify the physician if the combination of ~~*Private Duty Nursing*~~ PDN Services along with other community resources are not sufficient to ensure the health or safety of the child. ~~*(3-19-07)*~~( )

210. PRIVATE DUTY NURSING SERVICES: PROVIDER REIMBURSEMENT.
Provider claims for PDN Services require EVV compliance as described in Section 041 of these rules in order to be eligible for payment. ( )

21~~0~~1. - 214. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

267. NURSING FACILITY: TREATMENT OF NEWLY LICENSED FACILITIES WITH BEHAVIORAL CARE UNITS.

01. Criteria to Qualify as a New BCU On or After September 1, 2017. 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. (3-28-18)

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*~~ thirty percent (~~2~~30%), 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*~~ thirty percent (~~2~~30%) BCU occupancy requirement. ~~*(3-28-18)*~~( )

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. (3-28-18)

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. (3-28-18)

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. (3-28-18)

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 September 1, 2017, may be deemed eligible after meeting the following requirements: (3-28-18)

01. 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*~~ thirty percent (~~2~~30%). ~~*(3-28-18)*~~( )

03. BCU Payments. 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. (3-28-18)

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." (3-28-18)

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. (3-28-18)

c. The provider's total calculated rate will be subject to customary charge limitations and any other rate reductions implemented for other providers. (3-28-18)

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." (3-28-18)

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. (3-28-18)

(BREAK IN CONTINUITY OF SECTIONS)

301. PERSONAL CARE SERVICES: DEFINITIONS.

01. Children's PCS Assessment. A set of standardized criteria adopted by the Department to assess functional and cognitive abilities of children to determine eligibility for children's ~~*personal care services*~~ PCS. ~~*(3-29-10)*~~( )

02. Natural Supports. Personal associations and relationships that enhance the quality and security of life for people, such as family, friends, neighbors, volunteers, church, or others. (3-29-10)

03. Personal Care Services (PCS). A range of medically-oriented care services related to a participant's physical or functional requirements. These services are provided in the participant's home or personal residence, but do not include housekeeping or skilled nursing care. (3-29-10)

04. PCS Family Alternate Care Home. The private home of an individual licensed by the Department to provide ~~*personal care services*~~ PCS to one (1) or two (2) children, who are unable to reside in their own home and require assistance with medically-oriented tasks related to the child's physical or functional needs. ~~*(3-29-10)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

304. PERSONAL CARE SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Certified Family Homes." The Personal Assistance Agency and the participant who lives in their own home are responsible to prepare the plan of care. (3-19-07)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: (3-29-10)

i. The physician's or authorized provider's information if applicable; (4-2-08)

ii. The results of the UAI for adults, the children's PCS assessment and, if applicable, the QIDP's assessment and observations of the participant; and (3-29-10)

iii. Information obtained from the participant. (3-19-07)

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. (3-19-07)

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. (3-19-07)

d. The plan of care or NSA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. (7-1-16)

02. Service Supervision. The delivery of PCS may be overseen by a licensed registered nurse (RN) or Qualified Intellectual Disabilities Professional (QIDP). The BLTC will identify the need for supervision. (3-20-20)

a. Oversight must include all of the following: (3-19-07)

i. Assistance in the development of the written plan of care; (3-19-07)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-19-07)

iii. Reevaluation of the plan of care as necessary; and (3-19-07)

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-19-07)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the BLTC, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight must include: (3-20-20)

i. Assistance in the development of the plan of care for those aspects of active treatment that are provided in the participant's personal residence by the personal assistant; (3-19-07)

ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-19-07)

iii. Reevaluation of the plan of care as necessary, but at least annually; and (3-19-07)

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. (3-19-07)

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: (3-29-10)

a. The children's PCS assessment or Uniform Assessment Instrument (UAI) for adults; (3-29-10)

b. The individual service plan developed by the Personal Assistance Agency; and (3-29-10)

c. Any other medical information that supports the medical need. (3-29-10)

04. PCS Record Requirements for a Participant in Their Own Home. ~~*The*~~ PCS records must be maintained ~~*on*~~ for all participants ~~*who*~~ receive~~*e*~~ing PCS in their own homes or in a PCS Family Alternate Care Home. ~~*(3-20-20)*~~( )

a. ~~*Written*~~ Documentation Requirements. ~~*The*~~ PCS provider must maintain ~~*written*~~ documentation of every visit made to the participant's home and must record the following minimum information: ~~*(3-19-07)*~~( )

i. Date and time of visit; (3-19-07)

ii. Length of visit; (3-19-07)

iii. Services provided during the visit; and (3-19-07)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-19-07)

b. Participant's Signature. The participant or legal guardian must ~~*sign the record of service delivery*~~ verify~~*ing that the*~~ services were delivered. ~~*The BLTC may waive this requirement if it determines the participant is not able to verify the service delivery.*~~ ~~*(3-20-20)*~~( )

c. Provider Signature. The Plan of Care must be signed by the provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. (7-1-16)

d. Copy Requirement. A copy of the information required in Subsection 304.04 of these rules must be maintained and available in a format accessible to the participant~~'s~~ *in their* home ~~*unless the BLTC authorizes the information to be kept elsewhere*~~. Failure to maintain this information may result in recovery of funds paid for undocumented services. ~~*(3-20-20)*~~( )

e. ~~*Telephone Tracking*~~ Electronic Visit Verification (EVV) System. ~~*Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system*~~ EVV systems as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 304.04 of these rules but may be used to generate documentation retained in the participant's home. ~~*(3-19-07)*~~( )

05. PCS Record Requirements for a Participant in a Residential Assisted Living Facility or Certified Family Home. The PCS records must be maintained on all participants who receive PCS in a Residential Assisted Living Facility (RALF) or Certified Family Home (CFH). ~~*(7-1-16)*~~( )

a. Participant in a ~~*Residential Assisted Living Facility*~~ RALF. The additional PCS record requirements for participants in ~~*Residential Assisted Living Facility*~~ RALF are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~*(7-1-16)*~~( )

b. Participant in a ~~*Certified Family Home*~~ CFH. The additional PCS record requirements for participants in ~~*Certified Family Homes*~~ CFHs are described in IDAPA 16.03.19, "Certified Family Homes." ~~*(7-1-16)*~~( )

c. Participant's Signature. The participant or legal guardian must sign the NSA agreeing to the delivery of services as specified. (7-1-16)

d. Provider Signature. The NSA must be signed by the supervisory nurse or agency personnel responsible for developing the NSA with the participant, and must indicate that they will deliver services according to the authorized NSA and consistent with home and community-based requirements. (7-1-16)

06. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the BLTC and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (4-4-13)

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical transportation, unless approved by the Department or its contractor under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.08 of this rule. (4-4-13)

03. Weighted Average Hourly Rate Methodology. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/ID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, ~~*QMRP,*~~ certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. ~~*(4-4-13)*~~( )

04. Payment for Personal Assistance Agency. Payment for personal assistance agency services will be paid according to rates established by the Department. (4-4-13)

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR.

Personal Assistance Agencies	WAHR x supplemental component	=	$ amount/hour

(4-4-13)

b. The Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. (4-4-13)

c. The Department will survey one hundred percent (100%) of ~~*personal care service*~~ PCS providers. Cost surveys are unaudited, but a provider that refuses or fails to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. ~~*(4-4-13)*~~( )

05. Payment Levels for Adults in ~~*Residential Assisted Living Facilities*~~ a RALF or ~~*Certified Family Homes*~~ CFH. Adult participants living in ~~*Residential Assisted Living Facilities (*~~RALFs~~*)*~~ or ~~*Certified Family Home*~~s CFHs will receive ~~*personal care services*~~ PCS at a rate based on their care level. Each level will convert to a specific number of hours of ~~*personal care services*~~ PCS. ~~*(3-19-07)*~~( )

a. Reimbursement Level I -- One point twenty-five (1.25) hours of ~~*personal care services*~~ PCS per day or eight point seventy-five (8.75) hours per week. ~~*(3-19-07)*~~( )

b. Reimbursement Level II -- One point five (1.5) hours of ~~*personal care services*~~ PCS per day or ten point five (10.5) hours per week. ~~*(3-19-07)*~~( )

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of ~~*personal care services*~~ PCS per day or fifteen point seventy-five (15.75) hours per week. ~~*(3-19-07)*~~( )

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of ~~*personal care services*~~ PCS per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. ~~*(3-19-07)*~~( )

06. Attending Physician Reimbursement Level. The attending physician or authorized provider ~~*will be*~~ are reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. ~~*(3-19-07)*~~( )

07. Supervisory RN and ~~*QMRP*~~ QIDP Reimbursement Level. The supervisory RN and ~~*QMRP*~~ QIDP ~~*will be*~~ are reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the Department or its contractor. ~~*(4-4-13)*~~( )

a. The number of supervisory visits by the RN or ~~*QMRP*~~ QIDP to be conducted per calendar quarter will be approved as part of the PCS care plan by the Department or its contractor. ~~*(4-4-13)*~~( )

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the Department or its contractor. (4-4-13)

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR. Based on the survey conducted, the

Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	$ amount/week

(4-4-13)

09. EVV Compliance. Provider claims for PCS require EVV compliance as described in Section 041 of these rules in order to be eligible for payment. ( )

308. PERSONAL CARE SERVICES (PCS): QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies, ~~*Residential Assisted Living Facilities*~~ RALFs, and ~~*Certified Family Homes*~~ CFHs furnishing PCS are responsible for assuring that they provide quality services in compliance with applicable rules. ~~*(7-1-16)*~~( )

02. Review Results. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (3-19-07)

03. Quality Improvement Plan. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (3-19-07)

04. HCBS Compliance. Personal Assistance Agencies are responsible for ensuring they meet the setting requirements described in Section 313 of these rules. ~~*Residential Assisted Living Facilities*~~ RALFs, and ~~*Certified Family Homes*~~ CFHs are responsible for ensuring that they meet the setting requirements described in Sections 313 and 314 of these rules. All providers furnishing PCS are responsible for ensuring they meet the person-centered planning requirements described in Sections 316 through 317 of these rules. PCS providers must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ~~*(7-1-16)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

324. AGED AND DISABLED WAIVER SERVICES: TARGET GROUP.
Persons who would be Medicaid eligible if residing in a nursing facility, require the level of care provided in a nursing facility, are over the age of eighteen (18), demonstrate significant disability on the ~~*Uniform Assessment Instrument (*~~UAI~~)~~, and have deficits that affect their ability to function independently. ~~*(3-19-07)*~~( )

325. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER: PARTICIPANT LIMITATIONS.
The number of Medicaid participants to receive waiver services under the ~~*Home and Community Based Services (*~~HCBS~~)~~ waiver for the aged and disabled will be limited to the projected number of users identified in the Department's approved waiver. If necessary, participants who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year. ~~*(3-19-07)*~~( )

326. AGED AND DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal

functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. (4-4-13)

02. Adult Residential Care Services. Adult residential care services consist of a range of services provided in a homelike, non-institutional setting that include ~~*residential care or assisted living facilities*~~ RALFs and ~~*certified family homes*~~ CFHs. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. ~~*(4-4-13)*~~( )

a. Adult residential care services consist of a range of services provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Assisted Living Facilities," that include: (4-4-13)

i. Medication assistance, to the extent permitted under State law; (4-4-13)

ii. Assistance with activities of daily living; (3-19-07)

iii. Meals, including special diets; (3-19-07)

iv. Housekeeping; (3-19-07)

v. Laundry; (3-19-07)

vi. Transportation; (3-19-07)

vii. Opportunities for socialization; (3-19-07)

viii. Recreation; and (3-19-07)

ix. Assistance with personal finances. (3-19-07)

x. Administrative oversight must be provided for all services provided or available in this setting. (3-19-07)

xi. A ~~*written*~~ documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. ~~*(3-19-07)*~~( )

b. Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Certified Family Homes," that include: (4-4-13)

i. Medication assistance, to the extent permitted under State law; (4-4-13)

ii. Assistance with activities of daily living; (4-4-13)

iii. Meals, including special diets; (4-4-13)

iv. Housekeeping; (4-4-13)

v. Laundry; (4-4-13)

vi. Transportation; (4-4-13)

vii. Recreation; and (4-4-13)

viii. Assistance with personal finances. (4-4-13)

ix. Administrative oversight must be provided for all services provided or available in this setting. (4-4-13)

x. A ~~*written*~~ documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. ~~*(1-1-13)*~~( )

03. Specialized Medical Equipment and Supplies. (4-4-13)

a. Specialized medical equipment and supplies include: (4-4-13)

i. Devices, controls, or appliances that enable a participant to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; and (4-4-13)

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (4-4-13)

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant. (4-4-13)

04. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. (4-4-13)

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (4-4-13)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized. (3-19-07)

05. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. (4-4-13)

06. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: (4-4-13)

a. Intermittent assistance may include the following. (4-4-13)

i. Yard maintenance; (3-19-07)

ii. Minor home repair; (3-19-07)

iii. Heavy housework; (3-19-07)

iv. Sidewalk maintenance; and (3-19-07)

v. Trash removal to assist the participant to remain in the home. (4-4-13)

b. Chore activities may include the following: (3-19-07)

i. Washing windows; (3-19-07)

ii. Moving heavy furniture; (3-19-07)

iii. Shoveling snow to provide safe access inside and outside the home; (3-19-07)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-19-07)

v. Tacking down loose rugs and flooring. (3-19-07)

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. (4-4-13)

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (4-4-13)

07. Companion Services. Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed. (4-4-13)

08. Consultation. Consultation services are services to a participant or family member. Services are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver. (4-4-13)

09. Home Delivered Meals. Home delivered meals are meals that are delivered to the participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: (4-4-13)

a. Rents or owns a home; (4-4-13)

b. Is alone for significant parts of the day; (4-4-13)

c. Has no caregiver for extended periods of time; and (4-4-13)

d. Is unable to prepare a meal without assistance. (4-4-13)

10. Homemaker Services. Homemaker services consist of performing for the participant, or assisting them with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks. (4-4-13)

11. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: (4-4-13)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (4-4-13)

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. (4-4-13)

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to their next place of residence or be returned to the Department. (4-4-13)

12. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: (4-4-13)

a. Rent or own a home, or live with unpaid caregivers; (4-4-13)

b. Are alone for significant parts of the day; (3-19-07)

c. Have no caregiver for extended periods of time; and (4-4-13)

d. Would otherwise require extensive, routine supervision. (3-19-07)

13. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, a ~~certified family home~~ CFH, a developmental disabilities agency, a ~~residential care or assisted living facility~~ RALF, or an adult day health facility. ~~(4-4-13)~~( )

14. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. (4-4-13)

15. Habilitation. Habilitation services assist the participant to reside as independently as possible in the community, or maintain family unity. (4-4-13)

a. Residential habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: (4-4-13)

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-30-07)

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-30-07)

iii. Daily living skills consist of 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, as well as following home safety, first aid, and emergency procedures; (3-30-07)

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to their community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific

training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-30-07)

v. Mobility consists of 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; or (3-30-07)

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-30-07)

vii. Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) are unable to accomplish on their own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver participant's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence. (4-4-13)

b. Day habilitation. Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain their maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (4-4-13)

16. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (3-30-07)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (4-4-13)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to beneficiaries of a supported employment program, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (4-4-13)

17. Transition Services. Transition services include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/ID to transition to a community-based setting. A participant is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days. (4-11-19)

a. Qualified Institutions include the following: (4-11-19)

i. Skilled, or Intermediate Care Facilities; (4-11-19)

ii. Nursing Facility; (4-11-19)

iii. Licensed Intermediate Care Facility for the Persons with Intellectual Disabilities (ICF/ID);

(4-11-19)

iv. Hospitals; and (4-11-19)

v. Institutions for Mental Diseases (IMD). (4-11-19)

b. Transition services may include the following goods and services: (4-11-19)

i. Security deposits that are required to obtain a lease on an apartment or home; (4-11-19)

ii. Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; and (4-11-19)

iii. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (4-11-19)

iv. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (4-11-19)

v. Moving expenses; and (4-11-19)

vi. Activities to assess need, arrange for and procure transition services. (4-11-19)

c. Excluded goods and services. Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, or diversion/recreational items such as televisions, DVDs, and computers. (4-11-19)

d. Service limitations. Transition services are limited to a total cost of two thousand dollars ($2,000) per participant and can be accessed every two (2) years, contingent upon a qualifying transition from an institutional setting. Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. (4-11-19)

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by Department staff or a contractor. The Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (4-4-13)

a. Services that are not in the individual service plan approved by the Department or its contractor are not eligible for Medicaid payment. (4-4-13)

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. (3-19-07)

c. The earliest date that services may be approved by the Department or its contractor for Medicaid payment is the date that the participant's individual service plan is signed by the participant or their designee. (4-4-13)

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-19-07)

a. The UAI; (3-19-07)

b. The individual service plan developed by the Department or its contractor; and (3-19-07)

c. Any other medical information that verifies the need for nursing facility services in the absence of the waiver services. (3-19-07)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department or its contractor. (4-4-13)

04. Individual Service Plan. All waiver services must be authorized by the Department or its contractor in the Region where the participant will be residing and services provided based on a ~~*written*~~ documented individual service plan. ~~*(4-4-13)*~~( )

a. The initial individual service plan is developed by the Department or its contractor, based on the UAI, in conjunction with: (4-4-13)

i. The waiver participant (with efforts made by the Department or its contractor to maximize the participant's involvement in the planning process by providing them with information and education regarding their rights); (4-4-13)

ii. The guardian, when appropriate; (3-30-07)

iii. The supervising nurse or case manager, when appropriate; and (3-19-07)

iv. Others identified by the waiver participant. (3-19-07)

b. The individual service plan must include the following: (3-19-07)

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-30-07)

iii. The providers of waiver services when known; (3-30-07)

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-19-07)

v. The signature of the participant or their legal representative, agreeing to the plan. (3-19-07)

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-19-07)

d. All services reimbursed under the Aged and Disabled Waiver must be authorized by the Department or its contractor prior to the payment of services. (4-4-13)

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the Department or its contractor. (4-4-13)

05. Service Delivered Following a ~~*Written*~~ Documented Plan of Care. All services that are provided must be based on a ~~*written*~~ documented plan of care. ~~*(3-30-07)*~~( )

a. The plan of care is developed by the plan of care team that includes: (3-30-07)

i. The waiver participant with efforts made to maximize their participation on the team by providing them with information and education regarding their rights; (3-30-07)

ii. The guardian when appropriate; (3-30-07)

iii. Service provider identified by the participant or guardian; and (3-30-07)

iv. May include others identified by the waiver participant. (3-30-07)

b. The plan of care must be based on an assessment process approved by the Department. (3-30-07)

c. The plan of care must include the following: (3-30-07)

i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; (3-30-07)

ii. Supports and service needs that are to be met by the participant's family, friends and other community services; (3-30-07)

iii. The providers of waiver services; (3-30-07)

iv. Goals to be addressed within the plan year; (3-30-07)

v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and (3-30-07)

vi. The signature of the participant or their legal representative. (3-30-07)

vii. The signature of the agency or provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. (7-1-16)

d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-30-07)

e. The Department's Nurse Reviewer monitors the plan of care and all waiver services. (7-1-16)

f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (3-30-07)

06. Individual Service Plan and ~~*Written*~~ Plan of Care. The development and documentation of the individual service plan and plan of care must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. ~~*(7-1-16)*~~( )

07. Provider Records. Records will be maintained on each waiver participant. (3-19-07)

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: (3-19-07)

i. Date and time of visit; (3-19-07)

ii. Services provided during the visit; (3-19-07)

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-19-07)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the Department or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. (4-4-13)

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained ~~in~~ and available in a format accessible to the participant~~'s living arrangement unless authorized to be kept elsewhere by the Department~~. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. ~~(4-4-13)~~( )

c. The individual service plan initiated by the Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. (4-4-13)

d. Record requirements for participants in ~~residential care or assisted living facilities~~ RALFs are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~(4-4-13)~~( )

e. Record requirements for participants in ~~certified family homes~~ CFHs are described in IDAPA 16.03.19, "Certified Family Homes." ~~(4-4-13)~~( )

f. EVV Systems as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 328.07 of this rule, but maybe used to generate documentation retained in the participant's home. ( )

08. Provider Responsibility for Notification. The service provider is responsible to notify the Department or its contractor, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (4-4-13)

09. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-19-07)

10. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date that services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. (3-19-07)

329. AGED AND DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-19-07)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (5-8-09)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (5-8-09)

a. To directly assure compliance with legal requirements related to employment of waiver service providers; (3-19-07)

b. To offer supportive services to enable participants or their families ~~consumers~~ to perform the required employer tasks themselves; ~~(3-19-07)~~( )

c. To bill the Medicaid program for services approved and authorized by the Department; (3-19-07)

d. To collect any participant participation due; (3-19-07)

e. To pay personal assistants and other waiver service providers for service; (3-19-07)

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (3-19-07)

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; (5-8-09)

h. To maintain liability insurance coverage; (5-8-09)

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; (5-8-09)

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (5-8-09)

03. Provider Qualifications. All providers of homemaker services, respite care, adult day health, transportation, chore services, companion services, attendant care, adult residential care, and home delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's Aged and Disabled waiver as approved by CMS. (4-4-13)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. (3-19-07)

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

04. Quality Assurance. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. (7-1-16)

a. The results of a quality assurance review conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (7-1-16)

b. The provider must respond to the quality assurance review within forty-five (45) days after the results are received from the Department. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (7-1-16)

c. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. (7-1-16)

05. HCBS Setting Compliance. Providers of Aged and Disabled waiver services are responsible for ensuring that they meet the person-centered planning and setting quality requirements described in Sections 311 through 318 of these rules, as applicable, and must comply with associated Department quality assurance activities. (7-1-16)

06. Specialized Medical Equipment and Supplies. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. (4-4-13)

07. Skilled Nursing Service. Skilled nursing service providers must be licensed in Idaho as a licensed

registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

08. Consultation Services. Consultation services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (4-4-13)

09. Adult Residential Care. Adult residential care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Certified Family Homes," or IDAPA 16.03.22, "Residential Assisted Living Facilities." (4-4-13)

10. Home Delivered Meals. Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure that: (4-4-13)

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (4-4-13)

b. Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (4-4-13)

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; (4-4-13)

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code"; (4-4-13)

e. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (4-4-13)

f. Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met. (4-4-13)

11. Personal Emergency Response Systems. Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. (4-4-13)

12. Adult Day Health. Providers of adult day health must meet the following requirements: (4-4-13)

a. Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (4-4-13)

b. Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Certified Family Homes." (4-4-13)

c. Services provided in a ~~*residential adult living facility*~~ RALF must be provided in a ~~*residential adult living*~~ facility that meets the standards identified in IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~*(4-4-13)*~~( )

d. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

e. Providers of adult day health must notify the Department on behalf of the participant, if the adult

day health is provided in a ~~certified family home~~ CFH other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. ~~(4-4-13)~~( )

f. Adult day health providers who provide direct care or services must be free from communicable disease. (4-4-13)

g. All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

13. Non-Medical Transportation Services. Providers of non-medical transportation services must: (4-4-13)

a. Possess a valid driver's license; (4-4-13)

b. Possess valid vehicle insurance; and (4-4-13)

c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

14. Attendant Care. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

15. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

16. Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (4-4-13)

17. Residential Habilitation Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a residential habilitation agency under IDAPA 16.04.17, "Residential Habilitation Agencies," and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (4-4-13)

a. Direct service staff must meet the following minimum qualifications: (3-30-07)

i. Be at least eighteen (18) years of age; (3-30-07)

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (4-4-13)

iii. Have current CPR and First Aid certifications; (3-30-07)

iv. Be free from communicable disease; (4-4-13)

v. Each staff person assisting with participant medications must successfully complete and follow the

"Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-30-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" (4-4-13)

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-30-07)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. (4-4-13)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (4-4-13)

i. Purpose and philosophy of services; (3-30-07)

ii. Service rules; (3-30-07)

iii. Policies and procedures; (3-30-07)

iv. Proper conduct in relating to waiver participants; (3-30-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-30-07)

vi. Participant rights; (3-30-07)

vii. Methods of supervising participants; (3-30-07)

viii. Working with individuals with traumatic brain injuries; and (3-30-07)

ix. Training specific to the needs of the participant. (3-30-07)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: (3-29-12)

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-30-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-30-07)

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

vi. Activities of daily living; (3-30-07)

vii. Body mechanics and lifting techniques; (3-30-07)

viii. Housekeeping techniques; and (3-30-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-30-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (4-4-13)

18. Day Habilitation. Providers of day habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

19. Respite Care. Providers of respite care services must meet the following minimum qualifications: (4-4-13)

a. Have received care giving instructions in the needs of the person who will be provided the service; (4-4-13)

b. Demonstrate the ability to provide services according to a plan of service; (4-4-13)

c. Be free of communicable disease; and (4-4-13)

d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

20. Supported Employment. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities, other comparable standards, or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (3-20-20)

21. Chore Services. Providers of chore services must meet the following minimum qualifications: (4-4-13)

a. Be skilled in the type of service to be provided; and (4-4-13)

b. Demonstrate the ability to provide services according to a plan of service. (4-4-13)

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-4-13)

d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. (4-4-13)

22. Transition Services. Transition managers as described in Section 350.01 of these rules are responsible for administering transition services. (4-11-19)

330. AGED AND DISABLED WAIVER SERVICES: PROVIDER REIMBURSEMENT.
The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. (3-19-07)

01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department, or as agreed upon by the Department's contractor and the provider, depending on the type of service provided. Adult residential care will be paid on a per diem basis, based on the number of hours and types of assistance required by the participant as identified in the UAI. (4-4-13)

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department or its contractor. Billing instructions will be provided by the Department's payment system contractor. (4-4-13)

03. Calculation of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (3-19-07)

04. EVV Compliance. Provider claims for the following Aged and Disabled Waiver Services require EVV compliance as described in Section 041 of these rules in order to be eligible for payment: ( )

a. Attendant Care; ( )

b. Homemaker; and ( )

c. Respite. ( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.21 – DEVELOPMENTAL DISABILITIES AGENCIES (DDA)

DOCKET NO. 16-0321-2001

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Proposed Rule Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2021 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-4605, Idaho Code, and under the authority of Executive Order 2020-13.

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

Executive Order 2020-13 directed agencies to review temporarily waived rules to identify those that can be permanently removed. The changes to telehealth rules enable developmental disabilities agencies flexibility in supervision of direct care staff. Subsequent amendments reduce unnecessary training requirements that are addressed in other rules within the chapter.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2020, Idaho Administrative Bulletin, Vol. 20-9, pages 61 through 64.

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 the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Eric Brown at (208) 334-0649.

Dated this 18th day of November, 2020.

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, and under the authority of Executive Order 2020-13.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than September 16, 2020.

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 Governor's Executive Order 2020-13 directed agencies to review temporarily waived rules to identify those that can be permanently removed. With the changes to telehealth, removing elements from Subsection 400.03 enables developmental disabilities agencies flexibility in supervision of direct care staff. The amendments to text under Section 410 reduce unnecessary training requirements that are addressed in other rules within the 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:

There is no anticipated fiscal impact to state or general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done to comply with Executive Order 2020-13.

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 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 September 23, 2020.

Dated this 23rd day of July, 2020.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0321-2001

STAFFING REQUIREMENTS AND PROVIDER QUALIFICATIONS
(Sections 400-499)

400. GENERAL STAFFING REQUIREMENTS FOR AGENCIES.
Each DDA is accountable for all operations, policy, procedures, and service elements of the agency. (7-1-11)

01. Agency Administrator Duties. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. (7-1-11)

02. Agency Administrator Qualifications. An agency administrator must have two (2) years of supervisory or management experience in a developmental disabilities services setting. (7-1-11)

03. Clinical Supervisor Duties. A clinical supervisor must be employed by the DDA on a continuous and regularly scheduled basis and be readily available ~~*on-site*~~ to provide for: ~~*(7-1-11)*~~( )

a. The supervision of service elements of the agency, including ~~*face-to-face*~~ supervision of agency staff providing direct care services; and ~~*(7-1-11)*~~( )

b. The ~~*observation and*~~ review of the direct services performed by all paraprofessional and professional staff on at least a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the DDA services. ~~*(7-1-11)*~~( )

04. Clinical Supervisor Qualifications. A person qualified to act as clinical supervisor of a DDA must meet the following requirements: (7-1-11)

a. Hold at least a bachelor's degree in a human services field from a nationally accredited university or college; and (7-1-11)

b. Provide documentation of one (1) year's supervised experience working with the population served; and (7-1-11)

c. Demonstrate competencies related to the requirements to provide intervention services as required by the Department; and (7-1-11)

d. Complete additional coursework as required by the Department; or (7-1-11)

e. Individuals working as Developmental Specialists or as Intensive Behavioral Interventionists prior to July 1, 2011, are qualified to provide clinical supervision until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013, to maintain their certification. (7-1-11)

f. The agency administrator and clinical supervisor can be the same individual. (7-1-11)

05. Limitations. If an agency administrator or a clinical supervisor also works as a professional delivering direct services, the agency must have policies and procedures demonstrating how the agency will continue to meet agency staffing requirements in Subsections 400.01 through 400.04 of this rule. (7-1-11)

06. Professionals. The agency must ensure that staff providing intervention services have the appropriate licensure or certification required to provide services. A person qualified to provide intervention services must also meet the following minimum requirements: (7-1-11)

a. Hold at least a bachelor's degree in a human services field from a nationally accredited university or college; (7-1-11)

b. Provide documentation of one (1) year's supervised experience working with participants with

developmental disabilities; (7-1-11)

c. Demonstrate competencies related to the requirements to provide intervention services as required by the Department; and (7-1-11)

d. Complete a supervised practicum and additional coursework as required by the Department; or (7-1-11)

e. Individuals working as Developmental Specialists or as Intensive Behavioral Interventionists prior to July 1, 2011, are qualified to provide intervention services until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013, to maintain their certification. (7-1-11)

07. Paraprofessionals. A person qualified to provide support services must meet the following minimum requirements: (7-1-11)

a. Meet the qualifications prescribed for the type of services to be rendered; (7-1-11)

b. Have received instructions in the needs of the participant who will be provided the service; and (7-1-11)

c. Demonstrate the ability to provide services according to a plan of service. (7-1-11)

08. Records of Licenses or Certifications. The agency must maintain documentation of the staff qualifications, including copies of applicable licenses and certificates. (7-1-11)

09. Parent or Legal Guardian of Participant. A DDA may not hire the parent or legal guardian of a participant to provide services to the parent's or legal guardian's child. (7-1-11)

401. -- 409. (RESERVED)

410. GENERAL TRAINING REQUIREMENTS FOR DDA STAFF.
Each DDA must ensure that all training of staff specific to service delivery to the participant is completed as follows: (7-1-11)

01. Yearly Training. The DDA must ensure that staff or volunteers who provide DDA services complete a minimum of twelve (12) hours of formal training each calendar year. Each agency staff providing services to participants must: (7-1-11)

a. Participate in fire and safety training upon employment and annually thereafter; and (7-1-11)

b. Be certified in CPR and first aid within ninety (90) days of hire and maintain current certification thereafter; and (7-1-11)

i. The agency must ensure that CPR and first-aid trained staff are present or accompany participants when services or DDA-sponsored activities are being provided. (7-1-11)

ii. Each agency staff person must have age appropriate CPR and first aid certification for the participants they serve. (7-1-11)

c. Be trained to meet any special health or medical requirements of the participants they serve. (7-1-11)

02. Sufficient Training. Training of all staff must include the following as applicable to their work assignments and responsibilities: (7-1-11)

~~***a.*** *Optimal independence of all participants is encouraged, supported, and reinforced through*~~

~~*appropriate activities, opportunities, and training;*~~ ~~*(7-1-11)*~~

~~*b*~~a. Correct and appropriate use of assistive technology used by participants; (7-1-11)

~~*c*~~b. Accurate record keeping and data collection procedures; (7-1-11)

~~*d. Adequate observation, review, and monitoring of staff, volunteer, and participant performance to promote the achievement of participant goals and objectives;*~~ ~~*(7-1-11)*~~

~~*e*~~c. Participant's rights, advocacy resources, confidentiality, safety, and welfare; and (7-1-11)

~~*f*~~d. The proper implementation of all policies and procedures developed by the agency. (7-1-11)

03. Additional Training for Professionals. Training of all professional staff must include the following as applicable to their work assignments and responsibilities: (7-1-11)

a. Correct and consistent implementation of all participants' individual program plans and implementation plans, to achieve individual objectives; (7-1-11)

b. Consistent use of behavioral and developmental programming principles and the use of positive behavioral intervention techniques. (7-1-11)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.17 – RESIDENTIAL HABILITATION AGENCIES

DOCKET NO. 16-0417-2001

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Proposed Rule Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2021 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-4601 et seq., Idaho Code, and under 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 Governor's Executive Order 2020-13 resulted in agencies reviewing temporarily waived rules that can be eliminated. The amendments to this chapter remove duplicative language.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2020, Idaho Administrative Bulletin, Vol. 20-9, pages 65 through 67.

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 the state general fund related to this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Eric Brown at (208) 334-0649.

Dated this 18th day of November, 2020.

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 39-4601 et seq., Idaho Code, and under 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 16, 2020.

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 Governor's Executive Order 2020-13 resulted in agencies reviewing temporarily waived rules that can be eliminated. These changes removing elements from Subsections 203.07-08, 204.02.a, 204.02.f, 204.02.h, and 204.j.iii will remove unnecessary duplication in the rule 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:

There is no anticipated fiscal impact to state or general funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these changes remove duplicative language.

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 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 September 23, 2020.

Dated this 23rd day of July, 2020.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0417-2001

203. DIRECT SERVICE STAFF.
Each direct service staff person for an agency must meet all of the following minimum qualifications: (7-1-18)

01. Age. Be at least eighteen (18) years of age. (7-1-18)

02. Education. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to a plan of service. (7-1-18)

03. First Aid and CPR Certification. Be certified in first aid and Cardio-Pulmonary Resuscitation (CPR) appropriate for the age of participants they serve prior to providing direct care or services to participants and maintain current certification thereafter. (7-1-18)

04. Health. Have signed a statement maintained by the agency that they are free from communicable disease, understands universal precautions, and follows agency policies and procedures regarding communicable disease. (7-1-18)

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. (7-1-18)

06. Criminal History Check. Have satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-18)

~~***07. Documentation of Job Description**. Have signed and received a copy of their job description from the agency stating that the requirements of their position have been explained.* (7-1-18)~~

~~***08. Documentation of Training Requirements**. Have documentation maintained by the agency showing they have met all training requirements as outlined in Section 204 of these rules.* (7-1-18)~~

204. DIRECT SERVICE STAFF TRAINING.
Each agency must ensure that all staff who provide direct services have completed training in accordance with these rules. (7-1-18)

01. Training Documentation. (7-1-18)

a. Training documentation must include the following: (7-1-18)

i. Direct service staff receiving the training; (7-1-18)

ii. Individual conducting the training; (7-1-18)

iii. Name of the participant; (7-1-18)

iv. Description of the content trained; and (7-1-18)

v. Date and duration of the training. (7-1-18)

b. Documentation of training must be available for review by the Department, and retained in each employee's record. (7-1-18)

02. Orientation Training. Orientation training must be completed prior to working with participants. The orientation training must include: (7-1-18)

~~***a.** Purpose and philosophy of services;* (7-1-18)~~

~~b~~a. Policies and procedures; (7-1-18)

~~c~~b. Proper conduct in working with participants; (7-1-18)

~~d~~c. Handling of confidential and emergency situations that involve the participant; (7-1-18)

~~e~~d. Participant rights to include personal, civil, and human rights; (7-1-18)

~~*f. Universal Precautions;* (7-1-18)~~

~~g~~e. Body mechanics and lifting techniques; (7-1-18)

~~*h. Housekeeping techniques;* (7-1-18)~~

~~i~~f. Maintenance of a clean, safe, and healthy environment; and (7-1-18)

~~j~~g. Skills training specific to the needs of each participant served must be provided by a residential habilitation professional and include the following: (7-1-18)

i. Instructional techniques including correct and consistent implementation of the participant's program plan or plan of care; and ~~(7-1-18)~~( )

ii. Managing behaviors including techniques and strategies for teaching adaptive behaviors~~; and~~. ~~(7-1-18)~~( )

~~*iii. Accurate record keeping procedures.* (7-1-18)~~

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. (7-1-18)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.03 – GENERAL PROVISIONS OF THE BOARD OF MEDICINE

DOCKET NO. 24-3303-2001

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Proposed Rule Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2021 Idaho State Legislature for final approval. The pending rule becomes final and effective at the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending non-fee rule. The action is authorized pursuant to Section 54-1806(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.

The purpose of this rulemaking is to update the general provisions of the Board of Medicine to delete certain provisions suspended for COVID-19 that the Board determined to be duplicative, unnecessary, or outdated. In addition, the Board removed outdated or duplicative language in other sections of the rule that were not suspended to streamline the chapter.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 2, 2020. Idaho Administrative Bulletin, Vol. 20-9, pages 71-74.

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:

Not applicable. The Board of Medicine is a dedicated funds agency, and therefore, there will be no fiscal impact to the state general fund. This non-fee rule also has no fiscal impact on the Board of Medicine funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Anne K. Lawler, Executive Director, (208) 327-7000.

Dated this 23rd day of October, 2020.

Anne K. Lawler, JD, RN
Executive Director
345 W. Bobwhite Court, Suite 150
Boise, Idaho 83706
Phone: (208) 327-7000
Fax: (208) 327-7005

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1) and 67-5220(2), Idaho Code, notice is hereby given that this agency initiated proposed rulemaking procedures. The action is authorized Pursuant to Section 54-1806(2), Idaho Code.

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

PUBLIC HEARING

Wednesday, September 23, 2020
5:00 - 6:00 p.m. (MDT)

Idaho State Board of Medicine
345 W. Bobwhite Court, Suite 150
Boise, ID 83706

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

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the intended rulemaking and the principal issues involved:

The purpose of this rulemaking is to update the general provisions of the Board of Medicine to delete certain provisions suspended for COVID-19 that the Board determined to be duplicative or outdated. In addition, the Board removed outdated or duplicative language in other subsections of the rule that were not suspended to streamline the 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 resulting from this rulemaking:

Not applicable. The Board of Medicine is a dedicated funds agency, and therefore, there will be no fiscal impact to the state general fund. This rule also has no fiscal impact on the Board of Medicine funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the changes made were in response to Executive Order 2020-13.

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 rules, contact Anne K. Lawler, Executive Director, (208) 327-7000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 23, 2020.

Dated this 7th day of August, 2020.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3303-2001

100. GENERAL QUALIFICATIONS FOR LICENSURE.

~~***01. Applicant**. An applicant must meet the statutory requirements of licensure. The Board may refuse licensure or to issue a permit if it finds the applicant has engaged in conduct prohibited by state law for that specific category of licensure; provided the Board will take into consideration the rehabilitation of the applicant and other mitigating circumstances.* (3-20-20)~~

~~***02. Licensure**. Each applicant must have attained the level of education required by the Board, and have passed an examination required by the Board, or be entitled to apply by Licensure by Endorsement, or provisional licensure, if applicable.* (3-20-20)~~

0~~3~~1. **Application**. All applications for license or permit will be made to the Board on forms supplied by the Board, will be verified, must include all requested information, and must include the nonrefundable application fee. (3-20-20)

0~~4~~2. **Application Expiration**. All applicants must complete their license application within one (1) year unless extended by the Board after filing an application for extension. Unless extended, applications that remain on file for more than one (1) year will be considered null and void and a new application and new fees will be required as if filing for the first time. (3-20-20)

0~~5~~3. **Personal Interview**. The Board may, at its discretion, require the applicant to appear for a personal interview. (3-20-20)

0~~6~~4. **Residence**. No period of residence in Idaho is required of any applicant, however, each applicant for licensure must be legally able to work and live in the United States. Original documentation of lawful presence in the United States must be provided upon request only. The Board may refuse licensure or to renew a license if the applicant is not lawfully present in the United States. (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

103. ~~*PROVISIONAL LICENSURE.*~~ (RESERVED)

~~*Where permitted by law, the Board may issue a provisional license to a person who has successfully completed the academic requirements required by the Board and has met all the other requirements for licensure set forth in statute, but who has not yet passed the relevant examination required by the Board for licensure in their specific profession.* (3-20-20)~~

~~***01. Application**. Each applicant for provisional licensure will submit a completed written application to the Board on forms prescribed by the Board, together with the application fee, and all requested information, including the affidavit of a monitor licensed to practice the same profession in the state who will undertake the supervision of the provisional licensee.* (3-20-20)~~

~~***02. Affidavit**. An affidavit must be signed by an monitor licensed in Idaho to practice the same profession, in which they affirm and attest to supervise and be responsible for the activities of the provisionally licensed provider being supervised and to review and countersign all records and documentation of services performed by the provisionally licensed provider.* (3-20-20)~~

~~***03. Supervision**. The practice of a provider holding a provisional license will be in direct association with an Idaho licensee of the same profession who shall is responsible for the activities of the provisionally licensed provider being supervised and will review and countersign all patient documentation performed by the provisionally licensed provider. The supervising monitor need not be physically present or on the premises at all times but will be available for telephonic consultation. The extent of communication between the monitor and the provisionally licensed provider will be determined by the competency of the individual, the treatment setting, and the diagnostic category of the patients.* (3-20-20)~~

104. INACTIVE LICENSE

01. Issuance of Inactive License. Any applicant who is eligible to be issued a license by the Board, except a volunteer license, may be issued, upon request, an inactive license to practice on the condition that he will not engage in the practice of the relevant profession in this state. An inactive license fee will be collected by the Board. (3-20-20)

02. Renewal of Inactive License. Inactive licenses will be issued for a period of not more than five (5) years and such licenses will be renewed upon payment of an inactive license renewal fee ~~*of no more than one hundred dollars ($100) for each renewal year*~~. The inactive license certificate will set forth its date of expiration.
~~*(3-20-20)*~~( )

03. Inactive to Active License. An inactive license may be converted to an active license by application to the Board and payment of required fees. Before the license will be converted the applicant must account for the time during which an inactive license was held. The Board may, in its discretion, require a personal interview. (3-20-20)

(BREAK IN CONTINUITY OF SECTIONS)

~~***152. NOTICE.***~~
~~*The Board will notify, in writing, a licensee under investigation within ten (10) business days of the commencement of the investigation, and will provide an opportunity for any licensee under investigation to meet with the Committee on Professional Discipline or Board staff before the initiation of formal disciplinary proceedings by the Board.*~~
~~*(3-20-20)*~~

153~~3~~2. ON SITE REVIEW.
The Board, by and through its designated agents, is authorized to conduct on-site reviews of the activities of its licensees at the locations and facilities in which the licensees practice at such times as the Board deems necessary. (3-20-20)

154~~4~~3. -- 200. (RESERVED)

(BREAK IN CONTINUITY OF SECTIONS)

~~***202. IDAHO LICENSE REQUIRED.***~~
~~*Any physician, physician assistant, respiratory therapist, polysomnographer, dietitian, athletic trainer, or naturopathic medical doctor who provides any telehealth services to patients located in Idaho must hold an active Idaho license issued by the Idaho State Board of Medicine for their applicable practice.*~~ ~~*(3-20-20)*~~

203~~3~~2. PROVIDER-PATIENT RELATIONSHIP.
In addition to the requirements set forth in Section 54-5705, Idaho Code, during the first contact with the patient, a provider licensed by the Idaho State Board of Medicine who is providing telehealth services must: (4-11-19)

01. Verification. Verify the location and identity of the patient; (4-11-19)

02. Disclose. Disclose to the patient the provider's identity, their current location and telephone number and Idaho license number; (4-11-19)

03. Consent. Obtain appropriate consents from the patient after disclosures regarding the delivery models and treatment methods or limitations, including a special informed consent regarding the use of telehealth technologies; and (4-11-19)

04. Provider Selection. Allow the patient an opportunity to select their provider rather than being assigned a provider at random to the extent possible. (4-11-19)

20~~4~~3. 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 is personally responsible to familiarize themself with the applicable Idaho community standard of care. If a patient's presenting symptoms and conditions require a physical examination, lab work or imaging studies in order to make a diagnosis, the provider shall not provide diagnosis or treatment through telehealth services unless or until such information is obtained. (4-11-19)

20~~5~~4. 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: (4-11-19)

01. Verification. Identification of the patient, the provider and the provider's credentials; (4-11-19)

02. Telehealth Determination. Agreement of the patient that the provider will determine whether or not the condition being diagnosed and/or treated is appropriate for telehealth services; (4-11-19)

03. Security Measures Information. Information on the security measures taken with the use of telehealth technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy and notwithstanding such measures; (4-11-19)

04. Potential Information Loss. Disclosure that information may be lost due to technical failures. (4-11-19)

20~~6~~5. MEDICAL RECORDS.
As required by Section 54-5711, Idaho Code, any provider providing telehealth services as part of his or her practice shall generate and maintain medical records for each patient. The medical record should include copies of all patient-related electronic communications, including patient-physician communications, prescriptions, laboratory and test results, evaluations and consultations, relevant information of past care, and instructions obtained or produced in connection with the utilization of telehealth technologies. Informed consents obtained in connection with the provision of telehealth services should also be documented in the medical record. The patient record established during the provision of telehealth services must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records. (4-11-19)

20~~7~~6. -- 999. (RESERVED)