PENDING RULES

COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

Senate 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

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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.

SENATE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

Table of Contents

2021 Legislative Session

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.07 – HOME HEALTH AGENCIES

DOCKET NO. 16-0307-2001

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 39-2401(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
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

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

2~~7~~8. Licensing Agency. The Department of Health and Welfare. (12-31-91)

2~~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
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Phone: (208) 334-5500
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202(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
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P.O. Box 83720
Boise, ID 83720-0036
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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 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)*~~

~~***e.***~~ 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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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. ~~(1-4-13)~~( )

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~~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~~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)

203. 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)

204. 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)

205. 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)

206. -- 999. (RESERVED)

IDAPA 41 – IDAHO PUBLIC HEALTH DISTRICTS
(PANHANDLE HEALTH DISTRICT #1)

DOCKET NO. 41-0101-2000

NOTICE OF OMNIBUS 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 upon the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and full force and effect upon adoption of the concurrent resolution.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-408 *et seq*., Idaho Code

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

This pending rule adopts and re-publishes the following existing rule chapter previously submitted to and reviewed by the Idaho Legislature under IDAPA 41, rules of the Panhandle Health District:

IDAPA 41
- 41.01.01, *Rules of Idaho Public Health District #1*.

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 Sept. 16, 2020, Idaho Administrative Bulletin, Vol. 20-9SE, pages 2210-2238.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2021 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mr. Erik Ketner, PHD#1 Environmental Health Section Manager at (208) 415-5224.

Dated this 22nd day of October, 2020.

Joe Righello
Division Administrator
Environmental and Health Protection Division
Panhandle Health District
8500 N. Atlas Road
Hayden, Idaho 83835
Phone: (208) 415-5200
Fax: (208) 415-5201

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 39-143, Idaho Code.

PUBLIC HEARING SCHEDULE: Opportunity for presentation of oral comments concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of the purpose of the proposed rulemaking:

This proposed rulemaking re-publishes the following existing temporary rule chapter previously submitted to and reviewed by the Idaho Legislature under IDAPA 41, rules of the Panhandle Health District:

IDAPA 41
- 41.01.01, *Rules of Idaho Public Health District #1.*

FEE SUMMARY: This rulemaking does not impose a fee or charge.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2021 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mr. Erik Ketner, PHD#1 Environmental Health Section Manager at (208) 415-5224.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

Dated this 19th day of August, 2020.

THE FOLLOWING IS THE TEXT OF OMNIBUS DOCKET NO. 41-0101-2000

IDAPA 41 – IDAHO PUBLIC HEALTH DISTRICTS
(PANHANDLE HEALTH DISTRICT #1)

41.01.01 – RULES OF IDAHO PUBLIC HEALTH DISTRICT #1

000. LEGAL AUTHORITY.
The rules and standards set forth hereinafter shall be known as the Environmental Code of Panhandle Health District 1. This Code is adopted pursuant to the authority granted to the District Board of Health under Chapter 4, Title 39, Idaho Code. The provisions of the Code are supplementary, and should be interpreted in a manner consistent with Chapter 1, Title 39, Idaho Code and any state or federal laws which establish exclusivity or primacy in a field of rule for another public entity as a matter of law. ( )

01. Conflict. In the event of any conflict between city or county ordinances or heretofore existing rules of county health boards and departments and this Code, the respective provision which more completely protects public health or the environment, prevails. Nothing in this Code is deemed to prevent the enforcement of any standard, or rule relating to air, water, or health quality now existing or hereinafter adopted by the State Board of Health and Welfare or any interested agency of the federal government. Nothing in this Code is deemed to conflict with the enactment by any city or county in the District of any ordinance or rule placing additional restrictions or limitations which contribute to enhancement of water, air, land, or health quality. Where the provisions of this Code conflict with state or federal statues or rules which preempt regulation of a particular subject or application of this Code in a particular manner, the preemptive state rule or federal regulation prevails to the extent that application of the conflicting rules cannot be accommodated. ( )

02. Policy. This Environmental Health Code is based on the recognition that pollution of the air, land, and waters of this district constitutes a menace to public health and welfare, creates public nuisances, is harmful to wildlife, fish, and other aquatic life, and impairs domestic, agricultural, industrial, recreational, and other beneficial uses of air, land, and water. It is the duty of the Board to establish the quality standards of the environment in the interest of health, individual and community alike, and to prevent the outbreak and spread of dangerous and infectious disease. ( )

001. TITLE AND SCOPE.

01. Title. This chapter is titled IDAPA 41.01.01, "Rules of Idaho Public Health District #1." ( )

02. Scope. These rules govern issues concerning the mission of Idaho Public Health District #1 as established by the Idaho Legislature, in particular addressing matters of local concern in order to protect public health and the environment in the counties that comprise the District. ( )

002. OFFICE – OFFICE HOURS – MAILING ADDRESS – STREET ADDRESS.

01. Office Hours. 8 a.m. to 5 p.m., except Saturday, Sunday and legal holidays. ( )

02. Mailing and Street Address. The District's mailing/street address is: Panhandle Health District, 8500 N. Atlas Road, Hayden, ID 83835. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
The following definitions apply: ( )

01. Board. The Board of Panhandle Health District 1. ( )

02. Code. Environmental Health Code of Panhandle Health District 1, including the several sections which follow and the entire series of rules now and hereinafter adopted by the Board and by the State Board of Health and Welfare. ( )

03. Floathouse. A watercraft that is not self-propelled and with a dwelling place on it for habitation by human beings, whether said habitat is seasonal, itinerant, temporary, or permanent; and whether the floathouse is attached to land, floating free in the water, or tied to a fixed structure. ( )

04. Health Officer. Means the Director of Panhandle Health District 1, or any agent or employee

thereof whose duties include enforcement of any provision of this Code. ( )

05. Public Sewage Treatment Facility. Any sewage collection and treatment system with more than two (2) individual service connections. ( )

06. Variance. A grant of relief from the literal application of a Panhandle Health District 1 rule upon a showing that undue hardship, related to unique characteristics of a site, would result from literal adherence to such rule. ( )

011. -- 099. (RESERVED)

100. WATER QUALITY CONTROL.

01. Sewage and Waste Disposal: Political Subdivisions. Any political subdivision within the District may enter into a sewage management plan agreement with the District, the purpose of which will be to establish permanent sewage disposal practices that will fulfill the needs and goals of the political subdivision and the responsibilities of the District. The Board has authority to enforce the provisions of sewage management plan agreements. ( )

02. Sewage and Waste Disposal: Prohibited Conditions. ( )

a. Domestic sewage, septage, sanitary sewage, industrial waste, agricultural waste, sewage effluent, or human excreta is not allowed to remain open to the atmosphere or on the surface of the ground in such a manner so as to be a source of noxious or offensive odors, to be dangerous to health, or to be a public nuisance. ( )

b. Domestic sewage, sanitary sewage, septage, industrial sewage, industrial waste, agricultural waste, sewage effluent, or human excreta is not allowed to endanger any source or supply of drinking water, or cause damage to any public or private property. ( )

c. Raw or untreated sewage, septage, or industrial waste, or agricultural waste is not allowed in any body of water, water course, or any underground water drain, any storm water drain, channel, or other surface water drain. ( )

101. -- 109. (RESERVED)

110. SEWAGE DISPOSAL ON THE RATHDRUM PRAIRIE IN KOOTENAI COUNTY, IDAHO.
The Board has determined that extensive use of subsurface wastewater disposal on the Rathdrum Prairie presents a threat to the public health by contamination of the Rathdrum Aquifer, which is a drinking water source. It is the intent of the Board to adopt rules to govern subsurface sewage disposal on the Rathdrum Prairie. ( )

01. Title. These rules, within this Section, are known and cited as the "Rathdrum Prairie Sewage Disposal Rules." ( )

02. Scope. The provisions of this Section apply to subsurface sewage disposal systems installed on the Rathdrum Prairie. ( )

03. Definitions. The following definitions apply to the Rathdrum Prairie sections of these rules. ( )

a. Sewage Loading. The total liquid volume of sewage produced on any given parcel of land and expressed as gallons/day. ( )

b. Dwelling Equivalent. The total sewage loading from a single family dwelling. When applied to structures or facilities other than housing units, a dwelling equivalent shall be equal to two-hundred and fifty (250) gallons per day or be equal to twenty (20) persons using a non-residential facility on forty (40) hour per week basis, with no wastewater generation except from restrooms. ( )

c. Rathdrum Prairie. That area of land situated in Kootenai County and more particularly defined by the USGS map describing the boundaries of the Rathdrum Prairie Aquifer identified and designated under the authority of Section l424(e) of the Safe Drinking Water Act (PL 93-523) (Federal Register, Vol. 43, No. 28 -Thursday, February 9, l978). ( )

d. Sewage Management Plan. A method of action, procedure, or arrangement approved by the Panhandle Health District 1 describing how collection, treatment, and disposal of sewage shall be addressed within the boundaries of a political subdivision and include a map of the area affected by the Sewage Management Plan. ( )

04. Subsurface Sewage Disposal Systems. ( )

a. All installations of subsurface sewage disposal systems must be made in compliance with the Code and the rules of the Idaho Department of Environmental Quality. ( )

b. A subsurface sewage disposal system for one (1) dwelling equivalent may be installed without requirements other than Subsection 110.04.a., if the system is on a single parcel of land of five (5) acres or larger in surface area and the total loading for that parcel does not exceed one (1) dwelling equivalent per five (5) acres, except where one (1) system is replacing another. Every parcel of land created after December 20, 1977, except as otherwise permitted by these rules, maintains the dwelling equivalent(s) allowed for the original parcel of land. ( )

c. No subsurface sewage disposal system may be installed on any parcel of land of less than (5) five acres in surface area except under the following conditions: ( )

i. The parcel of land is located within the boundaries of a public sewer district or municipality where the governing board has adopted a Sewage Management Plan approved by the Board which will result in the construction and operation of, or connection to, a central sewage treatment plant. The Sewage Management Plan area must be entirely within the boundaries of the municipality, and the Sewage Management Plan must include a map delineating the boundaries of the Sewage Management Plan Area; ( )

ii. Parcels of land less than five (5) acres in size and acquired or established prior to December 20, 1977, will be permitted for a subsurface sewage disposal system for a single-dwelling equivalent, provided such parcels meet all other rules governing individual and subsurface sewage disposal systems; or ( )

iii. Where one (1) subsurface sewage disposal system is replacing another with no increase in sewage loading. ( )

d. On all developments subject to the provisions of Subsection 110.04.c.iii., the subsurface sewage disposal system needs to have the dry or wet sewer system with necessary laterals installed within the development. All installations need to be done in coordination with local government planning, and approved by the state Department of Environmental Quality where applicable. ( )

e. Upon notification by the Health Officer the owner of any parcel of land utilizing a subsurface sewage disposal system shall disconnect such system from any buildings on his parcel of land and connect the building sewer from the buildings to a collection and treatment system whenever it becomes available for service to his parcel. ( )

111. -- 199. (RESERVED)

200. OPEN WATER PROTECTION.

01. Boats and Houseboats. ( )

a. It is unlawful for any boat, motorboat, floathouse, sailboat, or any other kind of boat containing wastewater facilities to be on the waters of any stream, river, or lake in Panhandle Health District 1 unless such wastewater facilities shall be sealed to prevent a discharge into any waters. The method of sealing such wastewater facilities is subject to the approval of Panhandle Health District 1. ( )

b. Any person authorized by the Health Officer or any law enforcement person may stop and board any boat on the said waters and examine the wastewater facilities on such boats to see that such facilities are properly closed and sealed. ( )

c. It is unlawful for any person to throw overboard, dump, or otherwise dispose of or discharge, or cause, permit, or suffer to be discharged, any garbage, refuse, rubbish, waste, or sewage from any boat into or upon the waters of any stream, river, lake, or other body of water within the boundaries of Panhandle Health District 1. ( )

d. If any watercraft located upon the waters of this District is found to have a marine toilet which is not in compliance with the requirements of this section, the Health Officer shall have the following alternative or cumulative powers to: ( )

i. Cause the marine toilet to be locked and sealed to prevent usage; ( )

ii. Require such watercraft to be removed from the waters of Panhandle Health District 1 until the marine toilets are made to conform with the requirements of this Code. ( )

02. Public and Private Marinas. ( )

a. Any marinas, whether public or private, providing moorage for vessels equipped with on-board wastewater facilities shall provide sewage waste disposal facilities. These facilities shall consist of a pump station that is capable of adequately cleaning waste retention tanks on the largest boat that could reasonably use the moorage. Such plans must be approved by the Department of Environmental Quality. ( )

b. All marinas, whether public or private, must provide shore-based toilet facilities for their users. ( )

03. Floathouses. ( )

a. All floathouses must have approved wastewater facilities. ( )

b. All discharges from all floathouses, whether old or new, regardless of source, are prohibited. ( )

201. -- 399. (RESERVED)

400. CRITICAL MATERIALS AT FIXED FACILITIES ON THE RATHDRUM PRAIRIE IN KOOTENAI COUNTY, IDAHO.

01. Purpose and Intent. The purpose and intent of this section is to provide agencies that are currently involved with emergency planning and emergency response duties and businesses with duties to report their handling of chemicals and other potentially hazardous materials, with a mechanism to meet the mandate of existing rules by facilitating channels of communication. It is also intended to aid in protection of the Rathdrum Prairie Aquifer in Kootenai County, designated as a sole source aquifer by the United States of America, from potential sources of contamination from materials handling and storage at facilities located over or adjacent to the Aquifer. The rules strive to achieve such protection through proper use of secondary containment systems at Fixed Facilities that use, store, manufacture or handle Critical Materials. Reporting these chemicals to the concerned agencies will facilitate coordination among industry, government agencies and response personnel so that they may more successfully meet the requirements of the following: ( )

a. Title III of the Superfund Amendments and Reauthorization Act of l986 (SARA III). ( )

b. The International Fire Code. ( )

c. The International Building Code. ( )

d. Local building, planning and zoning codes applicable to lands which overlie the Aquifer. ( )

e. Any applicable rules administered by any other state, federal or local agency which has jurisdiction over matters related to Critical Materials. ( )

02. Definitions. The following have the following definitions: ( )

a. Container. Any vessel used to hold critical materials. A single container is one not connected to any other container by way of valves, piping, etc. ( )

b. Critical Material. Any liquid, semi-liquid, flowable, or water soluble solid that is listed on the most current Superfund Amendments and Reauthorization Act, Title III (SARA III) List of Lists published by the Office of Solid Waste and Emergency Response, U.S. Environmental Protection Agency, Washington, D.C. or is required by the U.S. Occupational Safety and Health Administration to have a safety data sheet (SDS). ( )

c. Critical Materials Compliance Certificate (CMCC). A certificate indicating compliance with the reporting and secondary containment requirements of this rule. ( )

d. Critical Materials Use Activity. Any undertaking that involves the use, storage, manufacture or handling of Critical Materials at a Fixed Facility above the secondary containment quantity set forth in this rule, or incorporated into this rule by reference. ( )

e. Director. The Director of Panhandle Health District 1 or his designee. ( )

f. Fixed Facility. Any established land use, building, dwelling, structure or site upon which or wherein a Critical Material Use Activity is conducted. ( )

g. Key Box. A durable, locked box that holds keys firefighters or other emergency personnel may use to gain entry into a structure. The key box needs to be a type approved by the local fire chief pursuant to Section 10.209 of the Uniform Fire Code. ( )

h. Local Emergency Planning Committee (LEPC). A standing committee established by the Office of the Governor through the State Emergency Response Commission (SERC) to fulfill Emergency Planning and Community Right to Know requirements pursuant to SARA III. ( )

i. Safety Data Sheets (SDS). Documentation required by OSHA to provide a description of the characteristics and potential hazards of a wide range of substances that are potentially Critical Materials. ( )

j. NFPA 704. The National Fire Protection Association's placarding system used to identify the health hazard, flammability, reactivity and potential to react with water of a particular substance. ( )

k. Secondary Containment Quantity. The quantity of a Critical Material that requires compliance with this rule. For those Critical Materials specifically listed in the SARA III List of Lists (or as otherwise noted) the following quantities of qualifying substances are subject to this rule: ( )

i. SARA Section 302 Extremely Hazardous Substances - ten (10) pounds in the aggregate, exclusive of solvent or other medium or, one hundred (100) pounds in the aggregate, inclusive of solvent or other medium. ( )

ii. CERCLA Hazardous Substances (listed in 40 CFR 302, Table 302.4) - one hundred (100) pounds in the aggregate, exclusive of solvent or other medium or, one thousand (1000) pounds in the aggregate, inclusive of solvent or other medium. ( )

iii. SARA Section 313 Toxic Chemicals - one hundred (100) pounds in the aggregate, exclusive of solvent or other medium or, one thousand (1000) pounds in the aggregate, inclusive of solvent or other medium. ( )

iv. SARA Section 311 and 312 Chemicals (Not listed in the List of Lists) for which OSHA MSDS

must be developed pursuant to OSHA Hazard Communication Standards - five thousand (5000) pounds in the aggregate, inclusive of solvent or other medium. ( )

l. Secondary Containment System. Site improvements and/or development criteria that are designed to isolate and prevent Critical Materials from entering the soil or surface or ground waters. ( )

m. Rathdrum Prairie Aquifer (Aquifer). The underground water source identified and designated under the authority of Section l424(e) of the Safe Drinking Water Act (PL 93- 523) (Federal Register, Vol. 43, No. 28 - Thursday, February 9, l978). ( )

03. Applicability. ( )

a. This rule applies to any person, firm, corporation, or government agency owning, operating, or proposing to locate, establish, or operate a Fixed Facility over the Aquifer or within a recognized Aquifer recharge area in Kootenai County, Idaho. Any Fixed Facility so located shall comply with the requirements of this rule prior to initiation of operation or engaging in any Critical Materials Use Activity, if established after the effective date of this rule. Every owner or operator of a Fixed Facility needs to show compliance with this rule by obtaining a Critical Materials Compliance Certificate appropriate for current operations. ( )

b. The following activities require a new application to the Panhandle Health District 1 to determine compliance with this rule: ( )

i. Establishing a new use that could qualify as a Fixed Facility. ( )

ii. Remodeling, operating changes, or expansion of an existing Fixed Facility which would modify the type or quantity of Critical Materials Use Activity. ( )

iii. Changes in the location or method of use, storage, manufacture or handling of Critical Materials in any Fixed Facility. ( )

iv. A change in ownership or addition of new Critical Materials meeting the quantity thresholds established by this rule at a Fixed Facility. ( )

c. Any CMCC granted is specific to that action and the application filed therefore. Subsequent actions, meeting the criteria set by Subsection 400.03.b., shall require separate plan reviews and approvals to obtain compliance. ( )

d. All businesses over the Rathdrum Prairie Aquifer in Kootenai County are subject to inspection in order to determine if they are governed by this rule. ( )

04. Application Requirements of Fixed Facilities Engaged in Critical Materials Use Activities. Each applicant for a Critical Materials Compliance Certificate must provide: ( )

a. Sufficient information to allow the Director to determine the type, quantity, and physical state of all Critical Materials that are used, stored, manufactured, or handled at the Fixed Facility location. The Director may require the applicant to provide a complete list of Critical Materials present at the Fixed Facility. ( )

b. Building plans and site development drawings showing compliance with the secondary containment requirements established by this rule. Such plans shall also provide confirmation that the secondary containment methods are compatible with the materials to be contained and that Critical Materials at the Fixed Facility are isolated from storm water or other surface waters on the site. The Director may require that any such plans be certified by a licensed engineer. The building and/or site plans need to show at least the following: ( )

i. Location of Critical Materials in buildings and other designated site areas. ( )

ii. Location of Key Box if needed by the local fire chief. ( )

iii. Location of NFPA 704 placards if needed by the local fire chief. ( )

c. Proof of contact and resultant acknowledgment from the agencies named below which have codes, standards, and/or rules which must be met by the applicant with respect to handling of Critical Materials. The Director will designate the agencies needing contact for each Fixed Facility based upon information provided by the applicant. ( )

i. Local Fire Department. ( )

ii. Local Emergency Planning Committee. ( )

iii. Kootenai County Department of Planning and Zoning. ( )

iv. Kootenai County Building Department. ( )

v. Applicable City Building Department. ( )

vi. Applicable City Planning and Zoning Department. ( )

vii. Bureau of Pesticides, Department of Agriculture. ( )

viii. Department of Environmental Quality. ( )

ix. Idaho Department of Water Resources. ( )

d. An opportunity for Panhandle Health District 1 to perform an inspection to assure compliance with secondary containment criteria previously approved through the plan review. If approved, and the agency review and reporting checklist (Subsection 400.04.c.) has been completed, a CMCC will be issued. The Director may delegate site inspection duties to officials of a cooperating agency. ( )

05. Performance Standards for Fixed Facilities. Each Fixed Facility, as defined in this rule, needs to conform to the following performance standards: ( )

a. Construct and maintain a secondary containment system for all Critical Materials. Said secondary containment system shall be designed to prevent infiltration of any Critical Materials into the ground in the event that they are released from their original storage containers. ( )

b. The secondary containment system and methods must be non-reactive and resistant to the materials to be contained and isolate the Critical Materials at the Fixed Facility from storm water, other surface waters on the site, and from reactive critical materials present in the same Fixed Facility. ( )

c. Secondary containment systems must be sized to contain at least one-hundred and ten percent (110%) of the volume of the largest container, or ten percent (10%) of the aggregate volume of all containers, whichever is greater, in any containment area within a Fixed Facility. ( )

d. The owner or operator of any Fixed Facility shall report the presence of any Critical Materials Use Activities to the responsible local, state, and federal agencies as specified by statutes, rules, and provisions of this rule. ( )

e. Any spilling, leaking, emitting, discharging, escaping, or leaching of any Critical Material into the secondary containment system or the environment must be reported to Panhandle Health District 1 or the local fire department immediately upon discovery of the release. ( )

f. Should conflict arise among the applications of local, state rules, and federal regulations regarding Critical Materials Use Activities, the rule that provides the greatest degree of protection to the Aquifer shall prevail, except where legal preemption of regulatory authority by state or federal agencies may require application of a different standard of protection. ( )

g. Each Fixed Facility is subject to biennial inspection to verify continued compliance with these rules. ( )

06. Violation. Any owner or operator of a Fixed Facility shall be deemed to have violated this rule if: ( )

a. A Fixed Facility is operated or if Critical Materials Use Activities are conducted on any site without first procuring a Critical Materials Compliance Certificate or if changes are made to Critical Materials Use Activities at a Fixed Facility as set forth in Section 400.03.b. without reapplying for a CMCC for the Fixed Facility. ( )

b. An owner or operator of a Fixed Facility submits knowingly false or incomplete reports to the Panhandle Health District or other responsible agencies or officials concerning the nature or quantity of Critical Materials present at a Fixed Facility governed by this rule. ( )

c. An owner or operator fails to implement or maintain secondary containment of Critical Materials at a Fixed Facility as necessitated by this rule. ( )

d. An owner or operator fails to comply with time and reporting standards for any Critical Materials Use Activities or fails to report any discharge of Critical Materials into the secondary containment system necessitated by this rule. ( )

401. -- 499. (RESERVED)

500. CONTAMINANT MANAGEMENT IN THE BUNKER HILL SUPERFUND SITE, SHOSHONE COUNTY, IDAHO.

01. Legal Authority. The Idaho Legislature has given the Board of Health of the District the authority to promulgate rules governing contaminant management pursuant to Section 39-416, Idaho Code. ( )

02. Purpose. The purpose of these rules is to ensure that activities involving excavations, building development, construction and renovation and grading within the Bunker Hill Superfund Site provide for the installation and maintenance of Barriers and implementation of other Contaminant management standards to preclude the migration of, and particularly, human exposure to Contaminants within the Site as necessary to protect the public health and the environment. It is imperative that redevelopment and future development proceed in a manner which minimizes the release of Contaminants into the air or water to minimize exposure to workers, Site residents and the communities. Further, it is the purpose of these rules to complement existing land use authorities and permitting processes, and to provide a screening process to determine whether proposed activities are subject to these rules. ( )

03. Definitions. The following terms are defined as follows: ( )

a. Applicant. Any person, contractor, public utility, government or other entity that is required to apply for an ICP Permit. ( )

b. Barrier. Any physical structure, material or mechanism which breaks the pathway between contaminants and human receptors, including but not limited to walls, floors, ceilings, soil, asphalt, concrete, fences, control over access, or other structure or covering which separates contaminants from contact with people or keeps contaminants in place. ( )

c. Board. The Board of Health of the District. ( )

d. B.O.P. Barrier Option Plan, which will be provided by an Applicant when required; such plans needs to set forth the location and type of Barrier which the Applicant intends to construct as part of the permitted work. ( )

e. Building Renovation. Construction activity to be performed on any structure involving any ceiling or insulation removal or disturbance of soil in basements or crawl spaces. ( )

f. Contaminants. Soil or other materials containing, or likely to contain, lead in excess of the levels established in Section 510 of these rules. ( )

g. Director. The Director of the District. ( )

h. Disposal. The placement of Contaminants into an authorized permanent repository. ( )

i. District or PHD. The Idaho Public Health District No. 1 (also the Panhandle Health District). ( )

j. Excavation. Any digging, breaching or disruption of a soil or other protective Barrier which may expose Contaminants to the environment. ( )

k. Hearing Officer. A lawyer, engineer or other professional trained in conducting hearings, appointed by the Board for purposes of conducting hearings authorized by these rules. ( )

l. ICP. The Institutional Controls Program for the Site. ( )

m. ICP Permit. The Contaminant management authorization for projects subject to these rules. ( )

n. Large Project. A project within the Site where one (1) cubic yard or more of soil containing Contaminants is disturbed or removed. Large Projects also include, but are not limited to, new building construction, demolition of existing buildings and construction of subdivisions and planned unit developments (PUD's) (and the infrastructure necessary to serve them) and construction within and maintenance of rights-of-way. ( )

o. Owner. Any person, partnership, or corporation having ownership, title, or dominion over property for which an ICP permit is sought. ( )

p. Record of Compliance. The record maintained by the District pursuant to Section 011 of these rules for Small Projects. ( )

q. Site. The Area within the boundaries of the Bunker Hill Superfund Site Allocation Map dated December 10, 1993 attached as Appendix 1 to these rules. ( )

r. Small Project. A project where less than one (1) cubic yard of soil containing Contaminants is disturbed or interior work that is not Building Renovation. ( )

s. Working Day. Monday through Friday, but does not include any holiday recognized as such by the state of Idaho. ( )

04. Statement of Intent. It is the intent of Idaho Public Health District No. 1 (the 'District') to work with local governments, the state of Idaho, the United States Environmental Protection Agency and private parties in managing Contaminants within the regulated area by way of an Institutional Controls Program (herein referred to as the ICP). These rules establish standards for Barrier installation and maintenance, and other Contaminant management practices. These rules govern management of Contaminants by: ( )

a. Requiring ICP permits and requiring barriers for certain construction and excavation activities; ( )

b. Licensing contractors, utilities, and government entities which may disrupt or install Barriers, or otherwise disturb Contaminants; ( )

c. Adopting performance standards; ( )

d. Inspecting for project compliance as required; ( )

e. Regulating the movement and disposal of Contaminants; ( )

f. Making it unlawful to knowingly disrupt a barrier in a fashion likely to expose persons to contaminants. ( )

05. Additional Provisions by District. In conjunction with these Rules it is the intent of the District to provide, as needed: ( )

a. Technical assistance and testing; ( )

b. Health screening and intervention; ( )

c. That there will be a readily available repository for Contaminants; ( )

d. Clean soil to restore Barriers for Small Projects; ( )

e. Disposal containers to assist in removing contaminated soil for Small Projects and transport and disposal of such soil; ( )

f. Health and safety information and education to licensees and the public; ( )

g. Plastic, gravel and use of vacuums for interior projects; ( )

h. A database tracking system to assist the public, lenders, and potential purchasers of property within the Site; and ( )

i. Guidelines for managing Contaminants. ( )

501. -- 509. (RESERVED)

510. THE BUNKER HILL SUPERFUND SITE; APPLICATION OF REGULATIONS.
These rules apply to the Bunker Hill Superfund Site in Shoshone County, Idaho, more particularly as shown on the Bunker Hill Superfund Site Allocation Map identified as Appendix 1 to these rules. These rules do not apply to operations undertaken at the direction of, under the supervision of, and subject to inspection by, the United States Environmental Protection Agency. ( )

01. Standards Adopted. ( )

a. All Barriers now or hereinafter constructed within the Site shall be maintained and protected. ( )

b. Except as otherwise provided in this section, Contaminant management is required in connection with any Large or Small Project or Building Renovation involving the breaching or disturbance of a Barrier or the disturbance or migration of Contaminants exceeding one thousand (1000) ppm lead. ( )

c. No new PUD or subdivision may be occupied where the average concentration of Contaminants exceeds three hundred fifty (350) ppm lead or a single lot exceeds one thousand (1000) ppm lead without Contaminant management on any portion of the property that exceeds these levels. ( )

d. As necessary to protect public health and the environment, PHD may impose Contaminant management requirements, other than Barrier installations, on projects where soils exhibit lead concentrations in excess of three hundred fifty (350) ppm lead, particularly where a property has been remediated with either six (6) or twelve (12) inches of clean fill but Contaminants in the three hundred fifty to one thousand (350 - 1000) ppm lead range remain below the six (6) or twelve (12) inch depth and those Contaminants may be disturbed by a Large or

Small Project. ( )

e. No person may conduct, except in accordance with these rules, any activity within the Site which breaches a Barrier, may breach a Barrier, or disturbs the same, or otherwise results in a threat to public health or the environment from the migration of Contaminants through tracking on tires or vehicles, visible airborne dust, excavation, transport, disposal, remodeling, demolition, or run-on or run-off from stormwater or in any other manner. ( )

02. Barriers; Construction and Maintenance. ( )

a. Barriers are required as necessary to attain the standards described in Section 510. Temporary Barriers also may be required to prevent the migration of Contaminants during construction activities. ( )

b. Types of acceptable Barriers for specific uses and activities are set forth in Appendices 3, 4, and 5. ( )

c. All twelve (12) inch permanent permeable exterior Barriers required to be installed under the ICP which overlay soils having lead levels in excess of one thousand (1000) ppm shall have an underlying visual delineator at the twelve (12) inch depth. Visual delineators are not required if the soil underlying the Barrier has tested under one thousand (1000) ppm lead. Permanent impermeable Barriers such as concrete and asphaltic concrete do not require delineators. ( )

d. The minimum Barrier requirements for residential properties and other properties that are frequently used by children (zero (0) to twelve (12) years) and/or pregnant women are as follows: ( )

i. All soil which contains lead in excess of one thousand (1000) ppm and lies within twelve inches (12") of the final grade shall be removed, replaced, or covered as appropriate with clean earthen material such that, after all work is completed, the soil remaining in the top twelve inches (12") has less than one thousand (1000) ppm lead. Replacement material must meet the requirements listed in Section 008.06. Acceptable soil removal and Barrier thicknesses for these properties are set forth in Appendix 6. ( )

ii. Any such property with unrestricted access to an adjacent property not meeting the requirements of Subsection 510.02.a. shall restrict access to such adjacent property. ( )

e. The minimum Barrier requirements for properties that are not frequently used by children (zero (0) to twelve (12) years) and/or pregnant women are as follows: ( )

i. All soil which contains lead in excess of one thousand (1000) ppm and lies within six inches (6") of the final grade shall be removed, replaced, or covered as appropriate with clean earthen material such that, after all work is completed, the soil remaining in the top six inches (6") has less than one thousand (1000) ppm lead, and the replacement material meets the requirements listed in Section 510.02.f. ( )

ii. Acceptable soil removal and Barrier thicknesses for these properties are set forth in Appendix 7. ( )

f. No earthen materials containing, on average, more than one hundred (100) ppm of lead or arsenic, nor more than five (5) ppm of cadmium, with no individual sample containing more than one hundred fifty (150) ppm of lead, shall be utilized for a Barrier. ( )

g. Should any inconsistency exist between the wording of these rules and the wording in any appendix, the wording in the rule supercedes the wording in the appendix. ( )

03. ICP Permits. ( )

a. ICP Permits are required for: ( )

i. Large projects; ( )

ii. Building renovations. ( )

b. A permit is required for a change in use of property which has Contaminants located thereon to a use which requires an additional or more substantial Barrier; constructing or establishing such additional Barriers shall be required, unless waived by the District. ( )

c. A single annual permit covering a specific list of projects may be obtained from the District by entities eligible under Section 015 at the beginning of each year's construction season. ( )

511. CONTAMINANT MANAGEMENT RULES IN THE BUNKER HILL SUPERFUND SITE OPERABLE UNIT #3 INSTITUTIONAL CONTROLS ADMINISTRATIVE AREA, SHOSHONE AND KOOTENAI COUNTIES, IDAHO.

01. Purpose. The purpose of these Rules is to ensure that activities associated with excavation and grading such as infrastructure development and maintenance; building construction and renovation; and land development, redevelopment and/or modification within the Institutional Controls Administrative Area of the Bunker Hill Superfund Site Operable Unit #3 (OU-3) provide for the construction and maintenance of Contaminant Barriers and implementation of other Contaminant management requirements to preclude the release and migration of Contaminants as necessary to protect the public health and the environment. It is imperative that current and future development and construction activities proceed in a manner which minimizes the release of Contaminants into the environment to minimize exposure to Area residents, communities, to workers involved in Area project work, and to environmental receptors. Further, it is the purpose of these Rules to complement existing land use regulations and permitting processes, and to provide a screening process to determine whether proposed activities are subject to these Rules. These Rules will rely upon procedures and provisions applicable to the Institutional Controls Program set forth in Section 500 of these rules. Differences identified in Sections 511 and 512 of these rules, is deemed applicable only to the lands encompassed by OU-3. ( )

02. Implementation Policy and Standards. Implementation policy and standards which pertain to the interpretation and enforcement of these Rules or to the documentation of compliance with these Rules have been developed by PHD and are available for inspection and/or copying at cost at the PHD office, 35 Wildcat Way, Kellogg, ID 83837. ( )

03. Definitions. The following terms are defined as follows: ( )

a. Agricultural Land. Land used for pasturing animals or for cultivation and production of agricultural crops including conservation reserve activities. ( )

b. Applicant. Any person, contractor, public utility, government or other entity that is required to apply for an Institutional Controls Program (ICP) Permit. ( )

c. Access Restrictions. Physical barriers such as fences, barricades, curbs, barrier rocks, trenches, etc. that provide restricted access by vehicles, pedestrians, and animals to contaminated areas. ( )

d. Barrier. Any physical structure, material or mechanism which acts to break the pathway between Contaminants and human receptors, including but not limited to soil, crushed aggregate/gravel, asphalt and Portland cement concrete, fences, access restrictions, or other structure or covering which separates Contaminants from contact with people or keeps Contaminants in place. ( )

e. Board. The Board of Health of the Idaho Public Health District No. 1. ( )

f. B.O.P. Barrier Option Plan, a plan which will be provided by an Applicant, when required, that sets forth the location and type of Barrier which the Applicant intends to construct as part of the permitted work. ( )

g. Building Construction. Construction activity to be performed for any new structure involving disturbance of soil in excess of one cubic yard. ( )

h. Building Renovation. Construction activity to be performed on any existing structure involving ceiling or insulation removal, work in dirt crawl spaces or basements, or disturbance of soil in excess of one cubic yard. ( )

i. CERCLA. Comprehensive Environmental Response, Compensation, and Liability Act. ( )

j. Commercial Property. Retail, wholesale and secondhand businesses; public and common use areas; public buildings; and undeveloped properties accessed by a maintained road or street and zoned for commercial development as of the date of promulgation of these Rules. ( )

i. Type I. Commercial Property predominantly used by Sensitive Populations (e.g. daycare facilities, municipal parks, playgrounds, etc.) ( )

ii. Type II. All other Commercial Property. ( )

k. Contaminants. Soil or other material containing, or likely to contain, concentrations of lead equal to or greater than one thousand (1000) ppm or concentrations of arsenic equal to or greater than one hundred (100) ppm. ( )

l. Developed Recreation Area. Commercial and public recreation areas containing constructed features such as boat ramps, picnic areas, and campgrounds outside the city limits of incorporated communities in the Coeur d'Alene River corridor as defined in Subsection 511.04.s. of these rules. The Developed Recreation Areas of the Trail of the Coeur d'Alenes includes all constructed trail surfaces, stop and views, oases (rest stops) and trailheads, exclusive of all undeveloped areas within the trail right of way. ( )

m. Director. The Director of the Idaho Public Health District No. 1. ( )

n. Disposal. The placement of Contaminants into an authorized repository. ( )

o. Environmental Office. PHD office in Kellogg, ID. ( )

p. Excavation – Any digging, breaching or disruption of soil not including cultivation of Agricultural Lands and gardens or mining activities regulated under other state and federal programs which may release or expose Contaminants to the environment. ( )

q. Health Officer. The Director or designee. ( )

r. Hearing Officer. An attorney, engineer or other professional trained in conducting hearings, appointed by the Board for purposes of conducting hearings authorized by these Rules. ( )

s. Institutional Controls Administrative Area. The Area designated by the Administrative Area Map in Appendix 2 which includes areas of mining, milling, and smelting related contamination in the South Fork of the Coeur d'Alene River corridor from its headwaters to the confluence with the North Fork Coeur d'Alene River and from the confluence of the North and South Fork to the mouth of the River and its confluence with Coeur d'Alene Lake including adjacent floodplains, tributaries, and fill areas. The Area also includes the Trail of the Coeur d'Alenes inside and outside the administrative boundary indicated on the map in Appendix 2 except that portion within the exterior boundaries of the Coeur d'Alene Indian Reservation. The Area does not include any area within OU-1 and OU-2 (Box) which has a separate ICP, or any other area excluded under this rule. The Area also includes areas in the Coeur d'Alene River corridor, as defined above, outside the administrative boundary indicated on the map in Appendix 2 where testing has verified that Contaminants related to mining, milling, and smelting have come to lie and remediation is required. ( )

t. ICP. The Institutional Controls Program for the Institutional Controls Administrative Area as defined in Subsection 511.05.s. of these rules. ( )

u. ICP Permit. The Contaminant management authorization for projects subject to these Rules. ( )

v. Infrastructure. Facilities such as trails, roads, streets, highways, bridges; storm water, drinking water, and wastewater systems; flood prevention systems including dikes and levees; and utilities including electrical power and natural gas systems. ( )

w. Large Project. A project where one cubic yard or more of soil containing Contaminants is disturbed or removed. Large Projects include, but are not limited to, infrastructure construction and maintenance, building construction, renovation, and demolition, land development or any change in the use of land that may result in the release or migration of Contaminants. ( )

x. Owner. Any person, partnership, or corporation having ownership, title, or dominion over property for which an ICP permit is required. ( )

y. PHD. The Idaho Public Health District No. 1 (also the Panhandle Health District). ( )

z. PUD. Planned Unit Development. ( )

aa. Record of Compliance. The record maintained by the PHD pursuant to Section 523 of these rules for Small Projects. ( )

bb. Release. Any excavation, spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, dumping, or disposing of Contaminants into the environment. ( )

cc. Residential Property. Property used by private individuals or families as a residence, and undeveloped properties accessed by a maintained road or street and zoned for residential development as of the date of promulgation of these Rules. ( )

dd. Sensitive Populations. Pregnant women and children up to twelve (12) years old. ( )

ee. Small Project. A project where less than one (1) cubic yard of soil containing Contaminants is disturbed or interior work that is not Building Renovation. ( )

ff. Trail of the Coeur d'Alenes. All Developed Recreation Areas and undeveloped areas within the former Union Pacific Railroad Mullan and Wallace Branch right of way. ( )

gg. Working day. Monday through Friday, excluding any legal holiday recognized as such by the State of Idaho. ( )

04. Statement of Intent. It is the intent of the PHD to work with local governments, the State of Idaho, the United States Environmental Protection Agency, Federal Land Management Agencies (Bureau of Land Management, USDA Forest Service), Coeur d'Alene Tribe, and private parties in managing Contaminants within the regulated Institutional Controls Administrative Area by way of an ICP. These Rules establish standards for Barrier construction and maintenance, and other Contaminant management practices. These Rules do not address financial liability for Contaminant management resulting from a failure of a CERCLA remedy due to a natural disaster. These Rules govern management of Contaminants by: ( )

a. Requiring ICP permits and requiring barriers for certain construction and excavation activities; ( )

b. Licensing contractors, utilities, and state and local government entities which may disrupt or construct Barriers, or otherwise disturb Contaminants; ( )

c. Adopting performance standards; ( )

d. Inspecting for project compliance as required; ( )

e. Regulating the movement and disposal of Contaminants; ( )

f. Making it unlawful to knowingly disrupt a barrier in a fashion likely to expose persons or the environment to Contaminants; ( )

g. Maintaining records of ICP activities. ( )

05. Additional Provisions by PHD. In conjunction with these Rules it is the intent of the PHD to provide, depending on project size and complexity and at the discretion of PHD: ( )

a. Technical assistance and soil testing; ( )

b. Health screening and intervention; ( )

c. Readily available repositories for disposal of Contaminants; ( )

d. Clean material to restore Barriers for Small Projects; ( )

e. Disposal containers for Small Projects to assist in removal, transportation and disposal of contaminated soil; ( )

f. Health and safety information and education to licensees and the public; ( )

g. Sheet plastic, crushed aggregate and gravel, or other items as appropriate; ( )

h. A database tracking system to assist the public, lenders, and prospective purchasers of property within the Institutional Controls Administrative Area; ( )

i. Guidelines for managing Contaminants. ( )

512. APPLICATION OF REGULATIONS; INSTITUTIONAL CONTROLS ADMINISTRATIVE AREA. These Rules apply to the Institutional Controls Administrative Area as defined in Subsection 511.05.s. of these rules. These Rules do not apply to the direct operations of the United States Environmental Protection Agency including directing, supervising, and inspecting project work or on lands owned or otherwise under the jurisdiction, custody and control of the Coeur d'Alene Tribe or the Federal Land Management Agencies such as the USDA Forest Service and the Bureau of Land Management. These Rules do not apply to the Union Pacific Railroad or its contractors when conducting activities within the Trail of the Coeur d'Alenes pursuant to the requirements of the Consent Degree entered August 25, 2000 by the United States District Court for the District of Idaho (Case Nos. 91-0342 and 99-606). ( )

01. Standards Adopted. ( )

a. Except as otherwise provided in Section 512 of these rules, contaminant management is required on all properties within the Institutional Controls Administrative Area including properties that have been remediated; properties tested and scheduled for remediation; properties not yet tested; and properties testing below action levels in the top eighteen (18) inches where Large or Small Projects may disturb Contaminants below eighteen (18) inches in excess of one thousand (1000) ppm lead or one hundred (100) ppm arsenic. Contaminant management may include testing of untested areas by the Applicant; testing of deep soils (below eighteen (18) inches) by the Applicant where a project may result in deep excavations; and replacement and repair of remediation Barriers in accordance with Subsection 512.02 of these rules; or other management activities. Contaminant Management on Residential Properties and Commercial Properties existing as of the date of promulgation of these Rules and requiring remediation, but not yet remediated will not require construction of final barriers in accordance with Subsection 512.02 of these rules, by the owner, but may require dust, erosion, health and safety and temporary cap controls to prevent further migration onto lands of others. Final barrier construction will be the responsibility of the state of Idaho and United States Environmental Protection Agency if needed. Applicant performed soil testing will be conducted consistent with sampling and analytic procedures developed by PHD. ( )

b. Developed Recreation Areas with surface soil containing lead concentrations greater than seven

hundred (700) ppm lead and one hundred (100) ppm arsenic shall be capped pursuant to Subsection 512.02.c. of these rules. ( )

c. Agricultural and undeveloped land within the Institutional Controls Administrative Area are exempt from these Rules unless excavation and grading activities such as soil transport off site or development by the owner or his/her agents on these lands is likely to result in the release or migration of Contaminants from these lands to adjacent non-agricultural or undeveloped areas. ( )

d. All Barriers existing or hereinafter constructed shall be maintained and protected to original construction specifications. ( )

e. No new PUD or subdivision containing concentrations of Contaminants exceeding one thousand (1000) ppm lead or one hundred (100) ppm arsenic shall be developed without Contaminant management. ( )

f. No person may conduct, except in accordance with these Rules, any activity within the Institutional Controls Administrative Area which breaches a Barrier, may breach a Barrier, or disturbs the same, or otherwise results in a threat to public health or the environment from the migration of Contaminants through tracking on tires or vehicles, visible airborne dust, excavation, transport, disposal, renovation, demolition, or run-on or run-off from stormwater or in any other manner on properties tested and requiring remediation and on properties not yet tested within the Institutional Controls Administrative Area ( )

02. Barriers; Construction and Maintenance. ( )

a. The minimum Barrier construction requirements for Residential and Type I Commercial Properties are as follows: ( )

i. All soil which contains lead equal to or in excess of one thousand (1000) ppm or arsenic equal to or in excess of one hundred (100) ppm and lies within twelve (12) inches of the final grade shall be removed and replaced with replacement material meeting the requirements of Subsection 512.02.d. of these rules. ( )

ii. Any such property with unrestricted access to an adjacent property not meeting the requirements of Subsection 512.01.a. of these rules, shall restrict access to such adjacent property. ( )

b. The minimum Barrier construction requirement for Type II Commercial Properties is a six (6) inch soil with vegetative cover barrier or six (6) inch crushed rock/gravel barrier or asphalt/Portland cement concrete cap. Excavation may be necessary for the installation of barriers to maintain grade or drainage requirements. ( )

c. The minimum Barrier construction requirement for Developed Recreation Areas is a six (6) inch soil with vegetative cover barrier or six (6) inch crushed rock/gravel barrier or asphalt/Portland cement concrete cap. Excavation may be necessary for the installation of barriers to maintain grade or drainage requirements. ( )

d. All twelve (12) inch deep Barriers of soil or crushed rock/gravel required pursuant to the ICP which overlay soils having concentrations of lead equal to or greater than one thousand (1000) ppm or arsenic concentrations equal to or greater than one hundred (100) ppm shall have an underlying visual delineator at the twelve (12) inch depth. Visual delineators are not required if the soil underlying the Barrier has tested under one thousand (1000) ppm lead and one hundred (100) ppm arsenic. Cap Barriers such as Portland cement and asphalt concrete do not require delineators. ( )

e. Soil and crushed aggregate/gravel imported for barrier material shall contain less than one hundred (100) ppm lead, thirty five (35) ppm arsenic and five (5) ppm cadmium based on average of backfill sampling results. No single sample of replacement materials may exceed one hundred fifty (150) ppm lead or forty five (45) ppm arsenic. ( )

f. Barriers needs to be maintained and repaired to original construction specifications. ( )

g. Contaminated waste material generated in the construction, maintenance and repair of Barriers shall be disposed of in designated repositories or as directed by PHD. ( )

03. ICP Permits. ( )

a. Permits are required for Large Projects and Building Renovations. ( )

b. A permit is required for a project which changes the use of a property containing Contaminants. A new Barrier or additional or more substantial Barrier may be required unless waived by the PHD. ( )

c. A single annual permit covering a specific list of projects may be obtained from the PHD by entities eligible under Section 531 of these rules, at the beginning of each year's construction season. ( )

513. -- 519. (RESERVED)

520. PERMIT APPLICATION AND ADMINISTRATION.

01. Application for ICP Permit. Application for an ICP Permit shall be made in writing at the Kellogg office of the District on forms provided by the District. ( )

02. Applicant Information. All Applicants shall provide the following information when applying for an ICP Permit with the District: ( )

a. Name, address and telephone number of the Applicant and the property owner. ( )

b. Location of the work and whether the work is being done on private or public property, or both. ( )

c. Description of work. The description must include methods of handling or storing, and transporting contaminated materials. A site plan may be required by the District if one has not been provided pursuant to the permit process. ( )

d. Dates work will be started and completed. ( )

e. Such other information as the District requires. ( )

03. Use of Discretion on Requirements by District. The District may, at its own discretion, waive certain application requirements or information, or require additional or alternative actions or information, depending upon the type and extent of the project and conditions encountered. In no instance may a waiver violate the intent of this rule and/or the Record of Decision for the relevant Operable Unit. ( )

04. Site Inspection or Waiver When Permit Required. Work requiring a permit may not commence until a site inspection has been made or waived by the District and a permit has been issued. ( )

05. Other Inspections and Requirements. All permits granted pursuant to this Rule remain subject to such other inspections and requirements prescribed by state or local governments. ( )

06. Work Involving Public Right-of-Way. If the permit involves work within any public right-of-way, the appropriate agencies must be notified of the work by the entity receiving the permit. ( )

521. INSPECTION.

The Applicant shall notify the District by telephone when work is completed. Applicants shall call for inspection in accordance with the terms of the permit; forty-eight (48) hours notice (excluding weekends and holidays) to PHD needs to be provided. The inspector will note approval of the work in writing and enter same in the database tracking system, or note reasons for disapproval and steps which must be taken to complete the work. Upon completion of the work to the District's satisfaction, the District's final approval will be noted in the database tracking system. Such entry constitutes the Record of Compliance for such project. All work governed by these regulations is subject to inspection by the District or its designated agents and it is unlawful to obstruct or hinder any official, inspector or designated agent making an inspection. The District may obtain an inspection warrant if access to the property is

refused. The District reserves the right to waive the inspection requirement. ( )

522. PERMIT REVOCATION OR STOP WORK ORDER.
Any Permit may be revoked or a Stop Work Order may be issued, without notice by the District, for non-compliance with or violation of any of the provisions of this chapter or any requirement or limitation of the Permit. If a Permit is revoked, the District may take such steps as are necessary to eliminate any danger from contamination, including completion of work by the District. The Applicant, contractor and/or Owner may be required to pay all costs and expenses for abatement of any danger and/or completion of the project, including legal fees incurred by the District to obtain compliance. The District will endeavor to provide written notice, but reserves the right to act summarily to protect public health and the environment. ( )

523. RECORD OF COMPLIANCE.
A Record of Compliance for Small Projects which documents compliance with the performance standards established by these rules will be entered into the database tracking system based upon an inspection requested of PHD by the property owner or tenant. The Record signifies the property owner or tenant was informed of and provided with applicable performance standards and guidelines and materially complied with the same. ( )

524. -- 529. (RESERVED)

530. CONTRACTOR LICENSING.

01. License Required. Any contractor performing Large Projects, Building Renovation or transportation or disposal of Contaminants within the Site or the Institutional Controls Administrative Area which is likely to expose the contractor, workers or others to Contaminants, must be licensed by the District. There will be no charge for a contractor's license. It is unlawful for a contractor to work on a project requiring an ICP permit without a current contractor's license issued by PHD. A contractor's license will not be required of an owner working on his or her own property. ( )

02. Training. In order to obtain a contractor's license from the District, the Contractor must have those supervisors involved in activities dealing with Contaminants participate in training approved by the District and pass an annual examination focusing on the reasons for, and methods of, controlling Contaminants. The purpose of the examination is to assure that all of the Contractor's employees are aware of and observe the procedures and standards that will protect themselves and the public from the Contaminants. The District will create and administer the test. The trained supervisor must pass information on to employees as is necessary to protect their health and safety and assure compliance with these rules. The District will provide training which owners and employees may participate in. ( )

03. Bonding. Any contractor whose license has been revoked by the District within the past three (3) years must, as a condition of reinstatement and maintaining the status of a licensed contractor, be bonded in the minimum amount of two-thousand dollars ($2000). Said bond shall be at least five percent (5%) of the cost of any contract the contractor is engaged in whichever is greater, be in a form approved by the District, and must be suitable to insure payment for completion of Barrier work not completed by the Contractor. A cash deposit or other security acceptable to the District may be utilized in lieu of a bond. The District may establish a bonding program for all contractors, if deemed necessary to carry out these Rules. ( )

04. Suspension or Revocation of License. ( )

a. Upon a showing that a licensee has violated any provision of these Rules, or has violated any other health or building code within the boundaries of the Site or Institutional Controls Administrative Area, suspension or revocation of license may be imposed. Suspension may be made by any District health officer. Revocation may be made by the Director upon recommendation of the District health officer. Notification of suspension or revocation must be in writing. No suspension may be made for more than thirty (30) days without approval of the Director. Revocation of license may be made by the Director upon a showing of good cause. ( )

b. Appeal. Suspension or revocation may be appealed by the licensee to the Board in writing within thirty (30) days of receipt of notice of suspension or revocation. Appeal stays the suspension or revocation unless the Director makes a finding that such stay is likely to present a health risk to a person or persons. ( )

c. Any decision by the Board pertaining to a suspension or revocation of a license may be made only after a licensee has been accorded an opportunity for hearing at which the licensee has a right to appear and be heard, to be represented by counsel, to testify, to present evidence, to call witnesses and to rebut any evidence presented. A transcribable recording of all such hearings will be made and retained for at least six (6) months. Such hearing may be conducted by a hearing officer designated by the Board or by the Board itself. ( )

d. If a license is revoked, the contractor may, upon payment of any cleanup or remediation costs related to past work, reapply for reinstatement of license after one (1) year, however, a contractor whose license has been revoked may not obtain a new license under a different corporate or partnership status until this provision is satisfied. ( )

531. LICENSES FOR PUBLIC UTILITIES AND GOVERNMENT ENTITIES.
Upon a demonstration that supervisory employees of a public utility or government entity (city, county, special purpose district, or state of Idaho) have participated in an education program approved by, or provided by, the District, a utility company or government entity may receive an annual license which will allow their employees to perform excavation and grading operations without obtaining individual ICP permits. This license may be granted by the District and will require that the utility comply with performance standards and all other regulations contained herein or adopted by Resolution of the Board. All supervisory employees involved in and responsible for excavation and grading operations shall have participated in a District approved education program. The trained supervisor must pass information on to employees as is necessary to protect their health and safety and assure compliance with these rules. The District will provide training which owners and employees may participate in. Entities licensed under this section shall maintain a log of all excavations and grading operations on a form approved by the District. Such logs need to be forwarded to the District on a regular basis determined by the District. All licensees shall telephone the Shoshone or Kootenai County one-call locating service, as appropriate, prior to any excavation or grading operations. Licenses shall be renewed annually upon a showing that the utility or government entity has operated in compliance with this rule. This license may also be revoked as provided in Subsection 530.04. ( )

532. -- 539. (RESERVED)

540. PERFORMANCE OF WORK.

01. Completion of Work. All work done pursuant to an ICP Permit shall be completed in a neat and workmanlike manner and so scheduled as to cause the minimum interference with traffic or public use (if applicable) and a minimum dispersal of Contaminants. ( )

02. Work Delayed by Applicant. If the work is unduly delayed by the Applicant, and if the public interest reasonably so demands, the District has the authority, upon twenty-four (24) hours' written notice to the Applicant, to complete the work to the extent that the Barrier is restored and any hazardous material covered or removed. The actual cost of such work by the District (including legal fees), plus fifteen percent (15%) as an overhead charge, shall be charged to and paid by, the Applicant and/or the Owner. ( )

541. PERFORMANCE STANDARDS.
The Board will adopt, and from time to time amend, performance standards by Resolution; said standards to ensure that work is performed in a safe and responsible manner and specify how work will be completed. Said standards shall be applicable to, but not be limited to, the following: materials handling; dust control; erosion/runoff control; disposal; transportation; barrier construction; demolition; renovation; grading; and subdivision development. Performance standards so adopted will not amend any standard adopted within these rules, and these rules apply should any conflict arise between a rule and a performance standard. ( )

542. APPROVAL OF ALTERNATIVE STANDARDS.
Any person aggrieved by the substantive requirements of these rules or the performance standards, may appeal these requirements by providing a written request for approval of an alternative standard. The appeal shall be accompanied by an engineering report indicating why the appealing party should be relieved of the requirement for compliance or why the requested alternate standard is appropriate. At the Applicant's expense, the District may consult with its own engineer to confirm the applicability of these rules to the proposed project. The District health officer may approve an alternate standard where such approval does not jeopardize the public welfare or existing Barriers. The decision of

the District health officer will be in writing, stating the reasons therefor. ( )

543. OWNER AND APPLICANT RESPONSIBILITY FOR CLAIMS AND LIABILITIES.
Both the Owner and the Applicant are responsible to ensure that all rules contained herein are complied with. Applicant is responsible for all claims and liabilities arising out of work performed by the Applicant under the ICP Permit or arising out of the Applicant's failure to perform obligations with respect to these regulations. Owner is responsible for all claims and liabilities for work done by the Owner with or without a permit and for work done at the direction of the owner without a permit. Owner remains responsible to complete the project or restore the premises to a safe condition to the satisfaction of the District should the Applicant fail to complete or restore it.
( )

544. -- 899. (RESERVED)

900. ADMINISTRATIVE PROCEDURES, EXCEPTIONS, PENALTIES.

01. Responsibility of Permit Applicant. It is the responsibility of any person applying for, or required to apply for, a permit by this Code, to show affirmatively, by all reasonable means, that his undertaking complies with this Code or with any related rules, statutes, or ordinances. ( )

02. Permit Revocation. Any permit or permission, actual or implied, granted by the Health Officer or his predecessors may be revoked, for cause, by written notice sent to the permit holder or his agent. Any person, association, or corporation who continues to act under such permit or permission actual or implied, more than ten days after the sending or delivery of notice of revocation is presumed to be in violation of this code and subject to the penalties provided herein. ( )

03. Variance Standards. A variance may be granted only upon an affirmative showing by an applicant that a unique and undue hardship is caused by a physical characteristic of a site that is not of the applicant's making and that approval of the variance would not be contrary to the public interest or to the purposes of the Code. ( )

04. Variance Procedures. ( )

a. An applicant for a variance shall obtain a Variance Application Form from Panhandle Health District 1 and, after completing the application form, return it to the Environmental Office. The Variance Application shall require the applicant to provide, in addition to information required by the application form itself, the following:
( )

i. An accurate site plan showing development of the site in question, present and proposed, depicting all features relevant to the variance request. The Director, or his designee, shall identify information necessary to proper processing of the request if information other than that normally required needs to be supplied. The applicant shall describe the current and proposed use of the site in question. ( )

ii. A narrative statement addressing the efforts, including consideration of design alternatives, which the applicant has undertaken to comply with the rule from which a variance is sought. ( )

iii. A narrative statement explaining the nature of the hardship, if any, imposed by literal compliance with the rule in question. ( )

iv. A narrative statement explaining the effects of the requested variance on the interests of adjoining landowners and/or of the public at large. ( )

v. A narrative statement detailing what use could be made of the site in question if the requested variance were not granted. ( )

b. The completed Variance Application shall be returned to the Environmental Office accompanied by an initial filing fee as established by the Board. The completed application shall be submitted to the Panhandle Health District 1 Hearing Officer who will determine whether, on its face, it sets forth a colorable claim for a variance from the Code. If the Hearing Officer determines that the application does not set forth a colorable claim for variance, he

will return the application to the applicant with a written explanation of the action taken. Said initial determination and the accompanying explanation will be forwarded to the Board which will act upon the Hearing Officer's initial determination by affirming it or remanding it to the Hearing Officer for further proceedings. ( )

c. If the Hearing Officer determines that the application presents a colorable claim for a variance, he shall return the application to the Environmental Office with instructions to prepare a notice of public hearing concerning the requested variance. The applicant shall pay an additional processing fee if the Hearing Officer makes such a finding. Said fee may be adjusted as with all other Panhandle Health District 1 fees in accordance with a sliding scale coordinated with Federal poverty standards. ( )

d. The Environmental Office staff will notify the applicant that his application has passed the initial screening and that the names and mailing addresses, on self-adhesive labels, of all owners of land located within three hundred (300) feet of the external boundaries of the site in question must be provided. Said names will be provided or checked by a land title company or other business whose commercial purpose it is to provide such information. The applicant is solely responsible for the accuracy of such information. ( )

e. Using the mailing list provided by the applicant, notice of public hearing will be sent by first class mail and posted on the site in question in a conspicuous manner. The Environmental Office will maintain records verifying completion of the notification process. Mailing and posting shall be accomplished at least fifteen (15) days prior to the date of the hearing established by the Hearing Officer. ( )

f. Upon the appointed date, the Hearing Officer shall conduct a public hearing concerning the variance request. The applicant, Panhandle Health District 1 staff, interested members of the public, and public agency representatives will be allowed to participate in such hearing. The Hearing Officer may establish time limits or other rules of procedure to expedite hearing of the request. The Hearing Officer shall establish a record of the hearing and see that a tape recording is made of the proceedings. Exhibits shall be identified in the record in order that they may be associated with the taped record of the hearing. ( )

g. Upon completion of the hearing and compilation of the record in each application, the Hearing officer shall prepare a recommended decision which is transmitted to the Board for final action. The Hearing Officer may recommend that the application be approved, be approved with conditions, or that the application be disapproved. His recommendation shall set forth facts found relevant to the decision, legal principles applicable to the recommended ruling, and conclusions drawn from the hearing process. ( )

h. At its next regular meeting, or as soon as the application can be placed upon its agenda, the Board will consider the record compiled and the Hearing Officer's recommendation and decide the request without further hearing by the Board. The Board may accept the recommendation of the Hearing Officer, may reverse the recommendation, or may modify the recommended decision for reasons to be found in the record. If the Board modifies or reverses the Hearing Officer's recommendation it shall set forth its reasons for doing so in writing with reference to parts of the compiled record or conclusions drawn therefrom. The Board may also elect to remand the request to the Hearing Officer for clarification or for further hearings to obtain information the Board deems essential. Confirmation of the Hearing Officer's recommendation may be accomplished by Board action adopting the Hearing Officer's decision as its own. Appeals from Board action may be taken in accord with provisions of Section 39-418, Idaho Code. ( )

901. (RESERVED)

902. VIOLATION AND ENFORCEMENT.

Violation of any provision of these rules is subject to the following enforcement procedures: ( )

01. Violation of Rules. Any person, association, or corporation, or the officers thereof, violating any of the provisions of these rules is deemed guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine not exceeding three hundred dollars ($300), or by imprisonment in the county jail for a term not exceeding six (6) months, or by both such fine and imprisonment. ( )

02. Liability of Violator. In addition to fine and imprisonment, any person, association, or corporation, or the officers thereof found to be in violation of these rules is liable, by civil action or restitution, for any expense

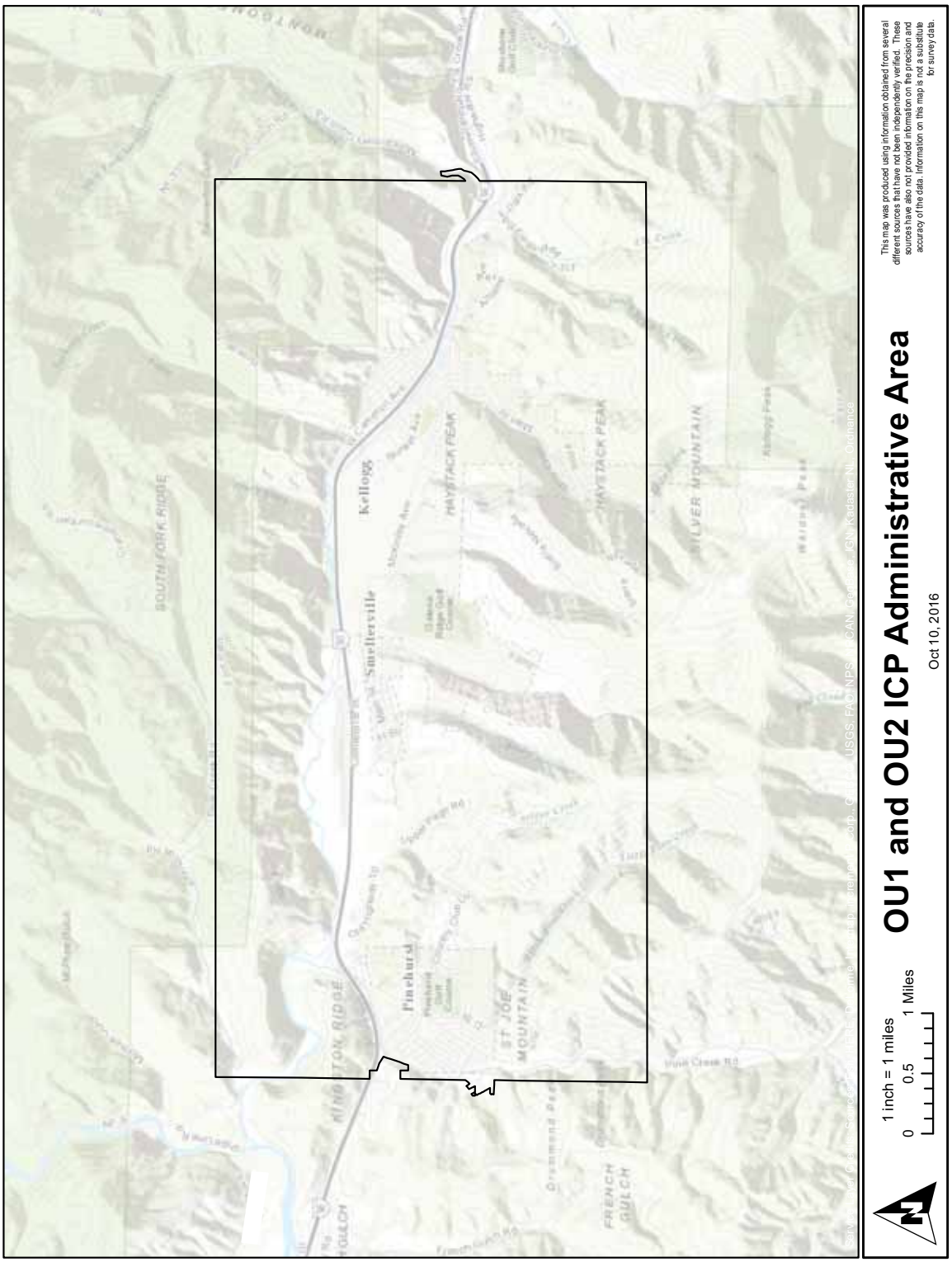
incurred by the District in enforcing this act, or in removing or terminating any nuisance or health hazard. ( )

03. Other Action. Any person, association, or corporation, or the officers thereof is additionally subject to civil court action, including an injunction or restraining order, and to such penalties, costs, or fees as may be necessary to compel compliance. ( )

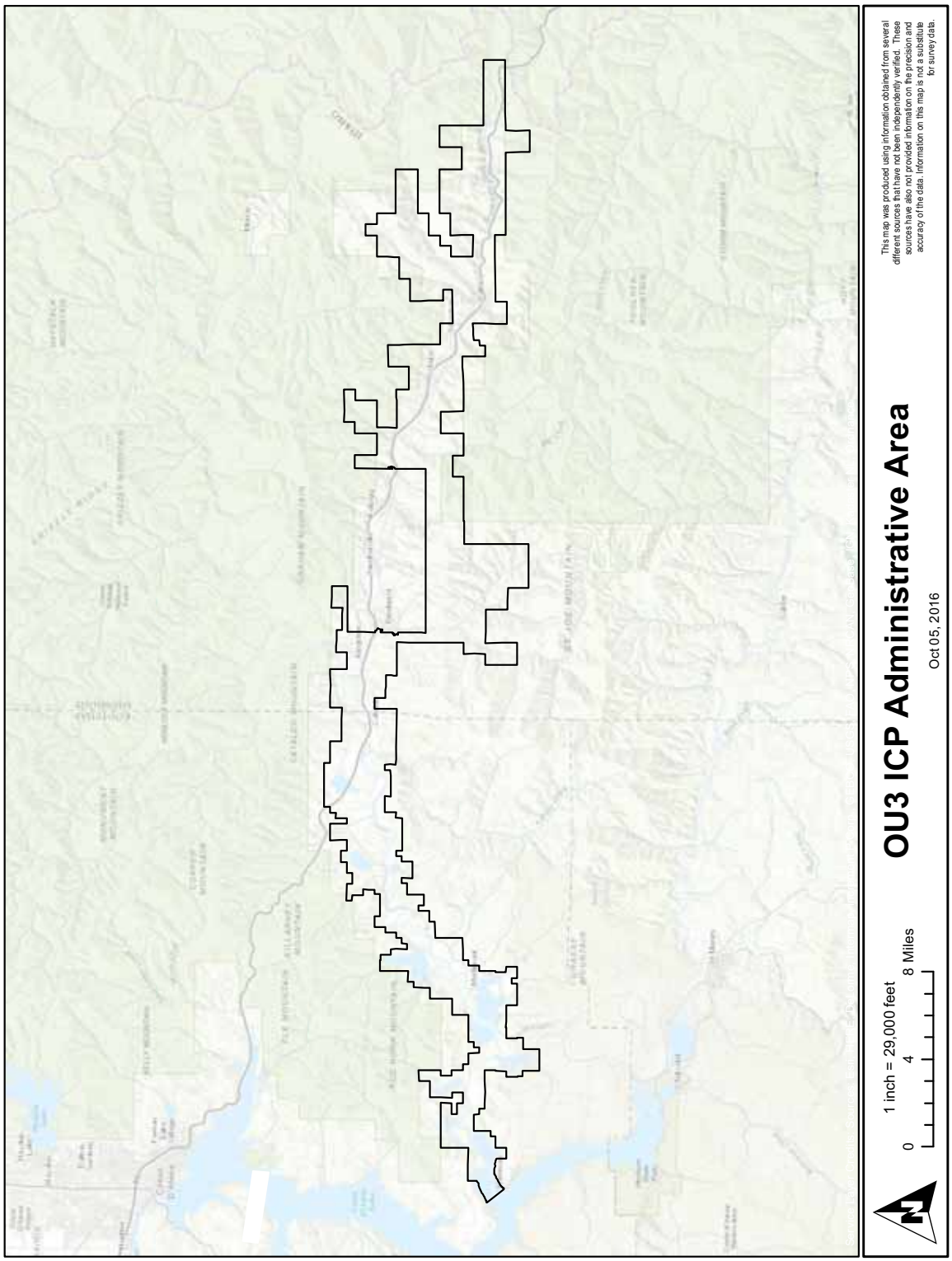
04. Successive Days in Violation. Each successive day in violation shall be considered a separate offense and be subject to individual penalties for each separate offense. ( )

903. -- 999. (RESERVED)

APPENDIX 1


OU1 and OU2 ICP Administrative Area
Oct 10, 2016
1 inch = 1 miles
0 0.5 1 Miles
This map was produced using information obtained from several different sources that have not been independently verified. These sources have also not provided information on the precision and accuracy of the data. Information on this map is not a substitute for survey data.
Kellogg
Smelterville
Pinehurst
BOUNDARY RIDGE
SOUTH FORK RIDGE
HAYSTACK PEAK
SILVER MOUNTAIN
ST JOE MOUNTAIN
FRENCH GULCH

APPENDIX 2


OU3 ICP Administrative Area
Oct 05, 2016
1 inch = 29,000 feet
0
4
8 Miles
This map was produced using information obtained from several different sources that have not been independently verified. These sources have also not provided information on the precision and accuracy of the data. Information on this map is not a substitute for survey data.

APPENDIX 3

APPLICABILITY OF BARRIER TYPES TO SITE USE ACTIVITIES: RESIDENTIAL

SITE USE ACTIVITIES																	
	Building Footprint		Landscaping			Vehicular Areas* Commercial classification of vehicular areas is subject to vehicle weight by volume.						Active Public Use Areas			Open Areas	
Barrier Type	Exposed	Sealed with Crawl Space	Flower/ Shrub Bed	Lawn Areas	Parking/ Loading Areas	Streets	Rural Roads	Alleys & Road Shoulders	Out-door Storage	Drive-ways	Walk-ways	Accessible to Children	Public Out-door Play Equipment	Vacant Lots	
12" Soil Cap	x		x	x							x	x		x	
24" Soil Cap	x		x	x					x		x	x	x	x	
12" Soil Cap with Sod & Grass	x		x	x								x	x	x	
24" Soil Cap with Sod & Grass	x		x						x		x	x	x	x	
6" Compacted Gravel with Restricted Access	x	x		x					x		x			x	
12" Compacted Gravel	x	x							x	x		x	x	x	
6" Clay Cap with Restricted Access	x	x												x	
Synthetic Membranes, Tyvek & Plastic		x													
Chip Seal on 12" Compacted Gravel Base	x						x	x	x		x	x	x	x	
Lignosite Spray on 12"Compacted Gravel Base	x						x	x	x		x		x	x	
Asphaltic Concrete	x				x	x	x	x	x	x	x	x	x	x	
Concrete	x	x			x	x	x	x	x	x	x	x	x	x	
12" Sand Cap			x												

APPENDIX 4

APPLICABILITY OF BARRIER TYPES TO SITE USE ACTIVITIES: COMMERCIAL

SITE USE ACTIVITIES																
	Building Footprint		Landscaping		Vehicular Areas* Commercial classification of vehicular areas is subject to vehicle weight by volume.						Active Public Use Areas			Open Areas	
Barrier Type	Exposed	Sealed with Crawl Space	Flower/ Shrub Bed	Lawn Areas	Parking/ Loading Areas	Streets	Rural Roads	Alleys & Road Shoulders	Drive-ways	Out-door Storage	Walk-ways	Accessible to Children	Public Out-door Play Equipment	Vacant Lots	
12" Soil Cap	x		x	x								x	x	x	
24" Soil Cap	x		x	x								x	x	x	
12" Soil Cap with Sod & Grass	x		x	x								x	x	x	
24" Soil Cap with Sod & Grass	x		x	x								x	x	x	
6" Compacted Gravel with Restricted Access	x	x												x	
12" Compacted Gravel	x	x					x		x	x	x	x	x	x	
6" Clay Cap with Restricted Access	x													x	
Synthetic Membranes, Tyvek & Plastic		x													
Chip Seal on 12" Compacted Gravel Base	x						x			x	x	x	x	x	
Lignosite Spray on 12"Compacted Gravel Base	x						x			x			x	x	
Asphaltic Concrete	x				x	x	x	x	x	x	x	x	x	x	
Concrete	x	x			x	x	x	x	x	x	x	x	x	x	
12" Sand Cap			x												

APPENDIX 5

APPLICABILITY OF BARRIER TYPES TO SITE USE ACTIVITIES: INDUSTRIAL

SITE USE ACTIVITIES																
	Building Footprint		Landscaping		Vehicular Areas* Commercial classification of vehicular areas is subject to vehicle weight by volume.						Active Public Use Areas			Open Areas	
Barrier Type	Exposed	Sealed with Crawl Space	Flower/ Shrub Bed	Lawn Areas	Parking/ Loading Areas	Streets	Rural Roads	Alleys & Road Shoulders	Drive-ways	Out-door Storage	Walk-ways	Accessible to Children	Public Out-door Play Equipment	Vacant Lots	
12" Soil Cap	x		x	x								x	x	x	
24" Soil Cap	x		x	x								x	x	x	
12" Soil Cap with Sod & Grass	x		x	x								x	x	x	
24" Soil Cap with Sod & Grass	x		x	x								x	x	x	
6" Compacted Gravel with Restricted Access	x	x												x	
12" Compacted Gravel	x	x					x		x	x	x	x	x	x	
6" Clay Cap with Restricted Access	x													x	
Synthetic Membranes, Tyvek & Plastic		x													
Chip Seal on 12" Compacted Gravel Base	x						x			x	x	x	x	x	
Lignosite Spray on 12"Compacted Gravel Base	x						x			x			x	x	
Asphaltic Concrete	x				x	x	x	x	x	x	x	x	x	x	
Concrete	x	x			x	x	x	x	x	x	x	x	x	x	
12" Sand Cap			x												

APPENDIX 6				
If the soil interval tests out **equal** to or **greater than** 1,000 ppm lead		The soil interval tests out **less than** 1,000 ppm lead		The minimum soil removal and replacement depth is
0 - 1”		1 - 6”, 6 - 12”		6”
1- 6”		0 - 1”, 6 -12”		6”
6 - 12”		0 - 1”, 1 - 6”		12”
12 - 18”	AND	0 - 1”, 1 - 6”, 6 - 12”	THEN	No Action
0 - 1”, 1 - 6”		6 - 12”		6”
0 - 1”, 6 - 12”		1 - 6”		12”
1 - 6”, 6 - 12”		0 - 1”		12”
None		0 - 1”, 1 - 6”, 6 - 12”		No Action

APPENDIX 7				
If the soil interval tests out **equal** to or **greater than** 1,000 ppm lead		The soil interval tests out **less than** 1,000 ppm lead		The minimum soil removal and replacement depth is
0 - 1”		1 - 6”		6”
1- 6”	AND	0 - 1”	THEN	6”
6 - 12		0 - 1”, 1 - 6”		No Action
None		0 - 1”, 1 - 6”		No Action