IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Medicaid

16.03.10 – Medicaid Enhanced Plan Benefits

Who does this rule apply to?
For those seeking medical assistance under Idaho Medicaid's Enhanced Plan and for Medicaid providers.

What is the purpose of this rule?
These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Dental benefits and outpatient behavioral health benefits are also contained in IDAPA 16.03.09. (For Medicaid eligibility, please see IDAPA 16.03.01,"Eligibility for Health Care Assistance for Families and Children."

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

Public Assistance and Welfare -
Public Assistance Law:
- Section 56-202(b), Idaho Code – Duties of Director of State Department of Health & Welfare
- Section 56-264, Idaho Code – Rulemaking Authority

Idaho Intermediate Care Facility Assessment Act:
- Section 56-1610, Idaho Code – Rulemaking Authority

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Division of Medicaid – Enhanced Plan Benefits
3232 West Elder Street
Boise, ID 83705

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5747 or 1-877-200-5441 (toll free)
Fax: (208) 364-1811
Email: Medicaid.Rules@dhw.idaho.gov
Webpages: http://medicaid.Idaho.gov and
https://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx

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000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), 56-264, and 56-1610, Idaho Code. (3-21-12)

02. General Administrative Authority. Title XIX and Title XXI, of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. (3-19-07)

03. Administration of the Medical Assistance Program. (3-19-07)

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. (3-19-07)

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. (3-19-07)

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules. (3-21-12)

04. Fiscal Administration. (3-19-07)

a. Fiscal administration of these rules is authorized by Title XIX and Title XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated by reference in Section 004 of these rules, apply unless otherwise provided for in these rules. (3-19-07)

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. (3-19-07)

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-19-07)

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Dental benefits and outpatient behavioral health benefits are contained in IDAPA 16.03.09. "Medicaid Basic Plan Benefits." (4-11-19)

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers' claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: (3-19-07)

a. Cost verification of actual costs for providing goods and services; (3-19-07)

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; (3-19-07)

c. Effectiveness of the service to achieve desired results or benefits; and (3-19-07)

d. Reimbursement rates or settlement calculated under this chapter. (3-19-07)

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." (3-19-07)

002. WRITTEN INTERPRETATIONS.

This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection. (3-20-20)

003. (RESERVED)

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following document: (3-19-07)

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at http://www.ecfr.gov/cgi-bin/text-idx?SID=3ec1965dbf5044d8f79b25d4d58c4cd1&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0. (3-19-07)

02. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-19-07)

03. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-19-07)

04. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-19-07)

05. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (3-19-07)

06. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov/. (3-19-07)

005. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, or Misconduct." (3-19-07)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Subsection 009.03 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

02. 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. (3-19-07)

03. Providers Subject to Criminal History and Background Check Requirements. The following

providers are required to have a criminal history and background check: (3-19-07)

a. Adult Day Health Providers. The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules. (4-4-13)

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. (4-2-08)

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. (4-2-08)

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules. (4-4-13)

e. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (4-2-08)

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. (4-2-08)

g. Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. (4-2-08)

h. Day Habilitation Providers. The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules. (4-4-13)

i. Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 009. (7-1-11)

j. Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. (4-2-08)

k. Personal Assistance Agencies Acting As Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. (3-19-07)

l. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. (3-19-07)

m. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. (4-2-08)

n. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. (7-1-11)

o. Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. (3-19-07)

p. Skilled Nursing Providers. The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules. (4-4-13)

q. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. (4-2-08)

r. Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. (7-1-11)

010. DEFINITIONS: A THROUGH D.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-19-07)

02. Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional (QIDP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. (3-19-07)

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining them in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-20-20)

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. (3-19-07)

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-19-07)

06. Appraisal. The method of determining the value of property as determined by an Appraisal Institute appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-19-07)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

08. 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 participants 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 unlicensed persons by a health care professional or the participant. Services are based on the person'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)

09. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. (3-19-07)

10. Auditor. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-19-07)

11. Audit Reports. (3-19-07)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-19-07)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-19-07)

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. (3-19-07)

12. **Bad Debts**. Amounts due to provider as a result of services rendered, but that are considered uncollectible. (3-19-07)

13. **Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-19-07)

14. **Capitalize**. The practice of accumulating expenditures related to long-lived assets that will benefit later periods. (3-19-07)

15. **Case Mix Adjustment Factor**. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-19-07)

16. **Case Mix Index (CMI)**. A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-19-07)

a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-19-07)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-19-07)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-19-07)

17. **Certified Family Home**. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. (3-19-07)

l8. **Chain Organization**. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-19-07)

19. **Claim**. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-19-07)

20. **Clinical Nurse Specialist**. A licensed registered nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

21. **Common Ownership**. An individual, individuals, or other entities who have equity or ownership in two (2) or more organizations that conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. (3-19-07)

22. **Compensation**. The total of all remuneration received, including cash, expenses paid, salary

advances, etc. (3-19-07)

23. **Control**. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. (3-19-07)

24. **Cost Center**. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-19-07)

25. **Cost Component**. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. (3-19-07)

26. **Cost Reimbursement System**. A method of fiscal administration of Title XIX and Title XXI that compensates the provider on the basis of expenses incurred. (3-19-07)

27. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-19-07)

28. **Cost Statements**. An itemization of costs and revenues, presented on the accrual basis, that is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. (3-19-07)

29. **Costs Related to Patient Care**. All necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-20-20)

30. **Costs Not Related to Patient Care**. Costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. (3-19-07)

31. **Customary Charges**. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. (3-19-07)

32. **Day Treatment Services**. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. (3-19-07)

33. **Department**. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. (3-19-07)

34. **Depreciation**. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-19-07)

35. **Developmental Disability (DD)**. A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person that appears before the age of twenty-two (22) years of age; and (3-19-07)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, that requires similar treatment or services or is attributable to dyslexia resulting from such impairments; (3-19-07)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration and individually planned and coordinated. (3-19-07)

36. **Direct Care Costs**. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: (3-19-07)

a. Direct nursing salaries that include the salaries of licensed registered nurses (RN), certified nurse's aides, and unit clerks; (3-19-07)

b. Routine nursing supplies; (3-19-07)

c. Nursing administration; (3-19-07)

d. Direct portion of Medicaid related ancillary services; (3-19-07)

e. Social services; (3-19-07)

f. Raw food; (3-19-07)

g. Employee benefits associated with the direct salaries: and (3-19-07)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-19-07)

37. **Director**. The Director of the Department of Health and Welfare or their designee. (3-19-07)

38. **Durable Medical Equipment (DME)**. Equipment other than prosthetics or orthotics that can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant. (5-8-09)

011. DEFINITIONS: E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. **Educational Services**. Services that are provided in buildings, rooms or areas designated or used as a school or as educational facilities; that are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and that are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. (3-19-07)

02. **Eligibility Rules**. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

03. **Emergency Medical Condition**. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (3-19-07)

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. (3-19-07)

b. Serious impairment to bodily functions. (3-19-07)

c. Serious dysfunction of any bodily organ or part. (3-19-07)

04. **Enhanced Plan**. The medical assistance benefits included under this chapter of rules. (3-19-07)

05. **EPSDT**. Early and Periodic Screening Diagnosis and Treatment. (3-19-07)

06. **Equity**. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. (3-19-07)

07. **Facility**. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. (3-19-07)

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (4-4-13)

b. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. (3-19-07)

c. "Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)" means an entity as defined in Subsection 011.30 in this rule. (4-4-13)

d. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. (3-19-07)

e. "Rural Hospital-based Provider" means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

f. "Rural Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. (4-4-13)

g. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. (3-19-07)

h. "Urban Hospital-based Nursing Facility" means a hospital-based nursing facility located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (4-4-13)

08. **Fiscal Intermediary Agency**. An entity that provides services that allow the participant receiving personal assistance services, or their designee or legal representative, to choose the level of control they will assume in recruiting, selecting, managing, training, and dismissing their personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (5-8-09)

09. **Fiscal Year**. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

10. **Forced Sale**. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner that requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

11. **Funded Depreciation**. Amounts deposited or held that represent recognized depreciation. (3-19-07)

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. (3-19-07)

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. (3-19-07)

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. (3-19-07)

16. Home and Community-Based Services (HCBS). HCBS are those long-term services and supports that assist eligible participants to remain in their home and community. (7-1-16)

17. ICF/ID Living Unit. The physical structure that an ICF/ID uses to house patients. (3-19-07)

18. Improvements. Improvements to assets that increase their utility or alter their use. (3-19-07)

19. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: (3-19-07)

a. Activities; (3-19-07)

b. Administrative and general care costs; (3-19-07)

c. Central service and supplies; (3-19-07)

d. Dietary (non-"raw food" costs); (3-19-07)

e. Employee benefits associated with the indirect salaries; (3-19-07)

f. Housekeeping; (3-19-07)

g. Laundry and linen; (3-19-07)

h. Medical records; (3-19-07)

i. Other costs not included in direct care costs, or costs exempt from cost limits; and (3-19-07)

j. Plant operations and maintenance (excluding utilities). (3-19-07)

20. Inflation Adjustment. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor plus one percent (+1%) per annum. (3-19-07)

21. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by IHS Markit, or its successor. If subsequent to the effective date of these rules, IHS Markit, or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with IHS Markit or its successor to have an Idaho-

specific index established. The national index is used when there is no state or regional index. (3-20-20)

22. **In-State Care**. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (3-19-07)

23. **Inspection of Care Team (IOCT)**. An interdisciplinary team that provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

a. At least one (1) licensed registered nurse; and (3-19-07)

b. One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: (3-19-07)

i. A consultant physician; or (3-19-07)

ii. A consultant social worker; or (3-19-07)

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (3-19-07)

24. **Instrumental Activities of Daily Living (IADL)**. Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (3-19-07)

25. **Interest**. The cost incurred for the use of borrowed funds. (3-19-07)

26. **Interest on Capital Indebtedness**. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. (3-19-07)

27. **Interest on Working Capital**. The costs incurred for borrowing funds that will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

28. **Interest Rate Limitation**. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/ID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. (3-19-07)

29. **Interim Reimbursement Rate (IRR)**. A rate paid for each Medicaid patient day that is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

30. **Intermediary**. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

31. **Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)**. An entity licensed as an ICF/ID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (3-19-07)

32. **Keyman Insurance**. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

012. DEFINITIONS: L THROUGH O.

For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. **Lease**. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. (3-19-07)

02. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for their use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. (3-19-07)

03. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-19-07)

04. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-19-07)

05. Licensed Bed Capacity. The number of beds that are approved by the Licensure and Certification Agency for use in rendering patient care. (3-19-07)

06. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-19-07)

07. Lower of Cost or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge or at a nominal charge are reimbursed fair compensation; which is the same as reasonable cost. (3-19-07)

08. MAI Appraisal. An appraisal that conforms to the standards, practices, and ethics of the Appraisal Institute and is performed by a member of the Appraisal Institute. (3-19-07)

09. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: (3-19-07)

a. A relatively fixed location in the building; (3-19-07)

b. Capable of being moved, as distinguished from building equipment; (3-19-07)

c. A unit cost of five thousand dollars ($5000) or more; (3-19-07)

d. Sufficient size and identity to make control feasible by means of identification tags; and (3-19-07)

e. A minimum life of three (3) years. (3-19-07)

10. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-19-07)

11. Medicaid. Idaho's Medical Assistance Program. (3-19-07)

12. Medicaid Related Ancillary Costs. For the purpose of these rules, those services provided in nursing facilities considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid related ancillaries. (3-19-07)

13. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (3-19-07)

14. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-19-07)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-19-07)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly. (3-19-07)

c. Medical services must be of a quality that meets professionally recognized standards of health care, be substantiated by records including evidence of such medical necessity and quality, and be made available to the Department upon request. (3-20-20)

15. **Medical Supplies**. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (3-19-07)

16. **Medicare Savings Program**. The program formerly known as "Buy-In Coverage," where the state pays the premium amount for participants eligible for Medicare Parts A and B of Title XVIII. (3-19-07)

17. **Minimum Data Set (MDS)**. A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. (3-19-07)

18. **Minor Movable Equipment**. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen may, at the facility's option, be considered minor movable equipment with the cost reported as a medical supply. The general characteristics of this equipment are: (3-19-07)

a. No fixed location and subject to use by various departments of the provider's facility; (3-19-07)

b. Comparatively small in size and unit cost under five thousand dollars ($5000); (3-19-07)

c. Subject to inventory control; (3-19-07)

d. Fairly large quantity in use; and (3-19-07)

e. A useful life of less than three (3) years. (3-19-07)

19. **Necessary**. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. (3-19-07)

20. **Negotiated Service Agreement (NSA)**. The plan reached by the resident and their representative, or both, and the facility or certified family home based on the assessment, physician or authorized provider's orders, admissions records, and desires of the resident. The NSA must outline services to be provided and the obligations of the facility or certified family home and the resident. (3-19-07)

21. **Net Book Value**. The historical cost of an asset, less accumulated depreciation. (3-19-07)

22. **New Bed**. Subject to specific exceptions stated in these rules, a bed is considered new if it adds to the number of beds for which a nursing facility is licensed on or after July 1, 1999. (3-19-07)

23. **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. (3-19-07)

24. **Nonambulatory**. Unable to walk without assistance. (3-19-07)

25. **Nonprofit Organization**. An organization whose purpose is to render services without regard to gains. (3-19-07)

26. **Normalized Per Diem Cost**. Refers to direct care costs that have been adjusted based on the nursing facility's case mix index for purposes of making the per diem cost comparable among nursing facilities. Normalized per diem costs are calculated by dividing the nursing facility's direct care per diem costs by its nursing facility-wide case mix index, and multiplying the result by the statewide average case mix index. (3-19-07)

27. **Nurse Practitioner**. A licensed registered nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-19-07)

28. **Nursing Facility (NF)**. An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. The participants require medical or nursing care, or rehabilitation services for injuries, disabilities, or illness. (3-19-07)

29. **Nursing Facility Inflation Rate**. See the definition of Inflation Factor in Subsection 011.20 of these rules. (4-4-13)

30. **Ordinary**. Ordinary means that the costs incurred are customary for the normal operation of the business. (3-19-07)

31. **Out-of-State Care**. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-19-07)

013. DEFINITIONS: P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: (3-19-07)

01. **Patient Day**. (3-21-12)

a. For ICF/ID, a calendar day of care includes the day of admission and excludes the day of discharge, unless discharge occurs after 3:00 p.m. or it is the date of death. When admission and discharge occur on the same day, one (1) day of care is deemed to exist. (3-21-12)

b. For a nursing facility, a calendar day of care includes the day of admission and excludes the day of discharge, unless it is the date of death. When admission and discharge occur on the same day, one (1) day of care is deemed to exist. (3-21-12)

02. **Participant**. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-19-07)

03. **Patient**. The person undergoing treatment or receiving services from a provider. (3-19-07)

04. **Personal Assistance Agency**. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal assistants working for them, and is the employer of record as well as the actual employer. (5-8-09)

05. **Personal Assistance Services (PAS)**. Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services 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 instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. (5-8-09)

06. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (3-19-07)

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants." (3-19-07)

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. (3-19-07)

09. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (3-19-07)

10. Private Rate. Rate most frequently charged to private patients for a service or item. (3-19-07)

11. Property. The homestead and all personal and real property in which the participant has a legal interest. (3-19-07)

12. Property Costs. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. (3-19-07)

13. Property Rental Rate. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/ID facilities. (3-19-07)

14. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

15. Provider Agreement. A written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. (3-19-07)

16. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. (3-19-07)

17. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (3-19-07)

18. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. (3-19-07)

19. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-19-07)

20. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. (3-19-07)

21. Reasonable Property Insurance. Reasonable property insurance means that the consideration

given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. (3-19-07)

22. Recreational Therapy (Services). Those activities or services that are generally perceived as recreation such as fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). (3-20-20)

23. Regional Nurse Reviewer (RNR). A licensed registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. (3-19-07)

24. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Registered Nurse and who meets all the applicable requirements to practice as a licensed registered nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01 "Rules of the Idaho Board of Nursing." (3-19-07)

25. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider. (3-19-07)

26. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. (3-19-07)

27. Residential Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. (3-20-20)

28. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. (4-2-08)

29. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. (3-19-07)

30. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (3-19-07)

31. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-19-07)

32. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-19-07)

33. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. (3-19-07)

34. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-19-07)

35. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-19-07)

36. Third Party. Includes a person, institution, corporation, public or private agency that is liable to

pay all or part of the medical cost of injury, disease, or disability of a participant of medical assistance. (3-19-07)

37. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. (3-19-07)

38. **Uniform Assessment**. A set of standardized criteria to assess functional and cognitive abilities. (3-19-07)

39. **Uniform Assessment Instrument (UAI)**. A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Uniform Assessments of State-Funded Clients." (3-19-07)

40. **Updated Assessments**. Assessments are considered updated and current when a qualified professional with the same credential or the same qualifications of that professional who completed the assessment has reviewed such assessment and verified by way of their signature and date in the participant's file that the assessment continues to reflect the participant's current status and assessed needs. (3-29-12)

41. **Utilities**. All expenses for heat, electricity, water and sewer. (3-19-07)

42. **Utilization Control (UC)**. A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants or participants to Title XIX and Title XXI benefits in a nursing facility. (3-19-07)

43. **Utilization Control Team (UCT)**. A team of Regional Nurse Reviewers that conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. (3-19-07)

44. **Vocational Services**. Services or programs that are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. (3-19-07)

014. -- 019. **(RESERVED)**

GENERAL PARTICIPANT PROVISIONS

020. PARTICIPATION IN THE COST OF WAIVER SERVICES.

01. **Waiver Services and Income Limit**. A participant is not required to participate in the cost of Home and Community-Based (HCBS) waiver services unless: (3-19-07)

a. The participant's eligibility for medical assistance is based on approval for and receipt of a waiver service; and (3-19-07)

b. The participant is eligible for Medicaid if they meet the conditions referred to under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 787. (4-7-11)

02. **Waiver Cost-Sharing**. Participation in the cost of HCBS waiver services is determined as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." (3-19-07)

021. MEDICARE SAVINGS PROGRAM FOR PARTICIPANTS COVERED BY MEDICARE.

The Department has an agreement with the Centers for Medicare and Medicaid Services (CMS) to pay the premiums for Parts A and B of Title XVIII for each participant eligible for Medicare and medical assistance regardless of whether the participant receives a financial grant from the Department. (3-19-07)

01. **AABD Effective Date**. The effective date of the Medicare Savings Program for a participant approved for medical assistance and an AABD grant is the first month of eligibility for the AABD grant. (3-19-07)

02. SSI Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance who also receives SSI, but not AABD, is the first month of eligibility for medical assistance. (3-19-07)

03. Neither AABD or SSI Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance who does not receive an AABD grant or SSI is the first day of the second month following the month in which they became eligible for medical assistance. This would mean the third month of medical assistance eligibility for the participant. (3-19-07)

04. Update of Records. After the effective date of the Medicare Savings Program it takes the Social Security Administration up to one (1) month to update its records to show the Department's payment of the Medicare Savings Program premium. (3-19-07)

05. Policies for Treatment of the Medicare Savings Program. The Department advises each participant who is paying Parts A and B Medicare premiums to discontinue payments beginning the month the Medicare Savings Program becomes effective. Policies for treatment of the Medicare Savings Program for determining eligibility for medical assistance or AABD, grant amount for AABD, or patient liability are in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)." Policies for treatment of the Medicare Savings Program for determining participation of an HCBS participant are found in Section 020 of these rules. (3-19-07)

022. PARTICIPANT'S REQUIREMENTS FOR ESTATE RECOVERY.
A participant's estate may be obligated to pay the Medicaid program back for the amount Medicaid paid out for medical assistance during the participant's life. The requirements for that estate recovery are found in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 900. (3-19-07)

023. -- 024. (RESERVED)

025. GENERAL SERVICE LIMITATIONS.
Service limitations stated in these rules include any services received by a participant under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-19-07)

026. SELECTIVE CONTRACTING.
The Department may contract with a limited number of providers of certain Medicaid products and services. (7-1-11)

027. -- 029. (RESERVED)

GENERAL REIMBURSEMENT PROVISIONS

030. COST REPORTING.
The provider's Medicaid cost report must be filed using the Department designated reporting forms, unless the Department has approved an exception. The request to use alternate forms must be sent to the Department in writing, with samples attached, a minimum of ninety (90) days prior to the due date for the cost report. The request for approval of alternate forms cannot be used as a reason for late filing. (3-19-07)

031. -- 035. (RESERVED)

036. GENERAL REIMBURSEMENT.

01. Long-Term Care Facility Payment. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment that would be determined as reasonable costs using the Title XVIII Medicare standards and principles. (3-19-07)

02. Individual Provider Payment. The Department will not pay the individual provider more than the lowest of: (3-19-07)

a. The provider's actual charge for service; or (3-19-07)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-19-07)

c. The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a participant is eligible for both Medicare and Medicaid. The Department will not reimburse providers an amount in excess of the amount allowed by Medicaid, minus the Medicare payment. (3-19-07)

037. GENERAL REIMBURSEMENT: PARTICIPANT SERVICES.
The Department will evaluate provider reimbursement rates that comply with 42 U.S.C. 1396a(a)(30)(A). This evaluation will assure payments are consistent with efficiency, economy, and quality of care and safeguards against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. (4-4-13)

01. Applicable Participant Services. Unless otherwise provided in this chapter of rules, the following types of services are reimbursed as provided in this rule: (3-20-20)

a. The Personal Care Services (PCS) described in Sections 300-308 of these rules. (3-20-20)

b. The Aged and Disabled Waiver services described in Sections 320-330 of these rules. (3-20-20)

c. The Children's Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 520-528 of these rules. (3-20-20)

d. The Adult Developmental Disabilities Waiver services described in Sections 700-706 of these rules. (3-20-20)

e. The Adult Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 645-657 of these rules. (3-20-20)

02. Review Reimbursement Rates. The Department will review provider reimbursement rates and conduct cost surveys when an access or quality indicator reflects a potential access or quality issue described in this rule. (3-20-20)

03. Access. The Department will review annual statewide and regional access reports by service type comparing the previous twelve (12) months to the base-line year of State Fiscal Year 2012. The following measures will be used to determine when there is potential for access issues. (4-4-13)

a. Compare the change in total number of provider locations for service type to the change in eligible participants; or (4-4-13)

b. When participant complaints and critical incidence logs reveal outcomes that identify access issues for a service type. (4-4-13)

04. Quality. The Department will review quality reports required by each program used to monitor for patterns indicating an emerging quality issue. (4-4-13)

05. Cost Survey. The Department will survey one hundred percent (100%) of providers. Providers that refuse or fail to respond to the periodic state surveys may be disenrolled as Medicaid providers. 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. The Department will conduct cost surveys customized for each of the services identified in this rule. (3-20-20)

a. Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified in the Bureau of Labor Statistics website at www.bls.gov when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used. (4-4-13)

b. For employer related expenditures: (4-4-13)

i. The Bureau of Labor Statistics's report for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions will be used to determine the incurred employer related costs by each provider type. The website for access to this report is at www.bls.gov. (4-4-13)

ii. The Internal Revenue Service employer cost for social security benefit and Medicare benefit will be used to determine the incurred employer related costs by provider type. The website for access to this information is at www.irs.gov. (4-4-13)

c. Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate. (4-4-13)

038. SPECIALIZED REIMBURSEMENT: CERTAIN HOME AND COMMUNITY-BASED SERVICES. The Department will review provider reimbursement rates to ensure compliance with 42 U.S.C. 1396a(a)(30)(A). This review will assure payments are consistent with efficiency, economy, quality of care, and safeguard against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. (3-20-20)

01. Applicable Home and Community-Based Services. The home and community-based services provided by the following types of providers are reimbursed as described in this rule: (3-20-20)

a. Developmental Disability Agencies providing services to adults; (3-20-20)

b. Developmental Disability Agencies providing services to children; (3-20-20)

c. Residential Habilitation Agencies; (3-20-20)

d. Supported Employment Agencies; and (3-20-20)

e. Targeted Service Coordination Agencies. (3-20-20)

02. Timing, Description, and Results of Rate Reviews. (3-20-20)

a. Standard Rate Reviews. The Department will conduct a cost survey and review reimbursement rates at least once every five (5) years for each type of provider specified in this rule. Cost surveys will be conducted in the order and on the schedule established by the Department. (3-20-20)

b. Interim Rate Reviews. The Department will prepare an annual trigger analysis and publish the report on its Medicaid Providers webpage, http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/tabid/214/Default.aspx. This annual report will describe the triggers for interim rate review, a summary of the data reviewed for each trigger, and the Department's determination and rationale of whether each trigger was met. The Department will conduct an interim rate review upon the occurrence of one (1) or more of the following triggers: (3-20-20)

i. When substantiated participant complaints, critical incidents, or both, related to a lack of qualified providers indicate an emerging access issue; (3-20-20)

ii. When quality reports prepared by the Department or substantiated participant complaints and critical incidents related to the quality of services provided indicate an emerging quality issue; or (3-20-20)

iii. When the federal or Idaho state minimum wage requirement in effect at the time of the standard rate review significantly increases or decreases. (3-20-20)

c. No Obligation to Revise Rates. The Department is not required to revise reimbursement rates each time a rate review or cost survey is conducted. The results of a rate review or cost survey do not guarantee a change to the reimbursement rate. (3-20-20)

03. Cost Survey Procedures. (3-20-20)

a. Participation. The Department will survey one hundred percent (100%) of providers. A provider who refuses or fails to respond to the periodic cost surveys may be disenrolled as a Medicaid provider. (3-20-20)

b. Customization. The Department will conduct cost surveys customized for each type of provider identified in this rule. (3-20-20)

c. Independent Consultant. The Department will engage an independent cost survey consultant with expertise and experience in fee-for-service home and community-based services, including services for individuals with developmental disabilities. (3-20-20)

d. Provider Engagement. (3-20-20)

i. The Department will establish reimbursement advisory workgroups to advise on matters related to the specialized reimbursement specified in this rule, including notice and development of cost surveys, recommendation of Bureau of Labor and Statistics occupation profile or profiles utilized when setting new reimbursement rates, and other reimbursement-related matters presented by the Department. The Department will retain final decision-making authority over all matters presented to or reviewed by the workgroups. (3-20-20)

ii. The Department will provide reasonable prior notice of pending cost surveys to impacted providers. (3-20-20)

iii. The Department or its cost survey consultants will train providers how to complete the cost survey, and provide technical assistance to providers during the cost survey response period. (3-20-20)

04. Reimbursement Rate Setting Methodology. Reimbursement rates will be derived using a combination of four (4) cost components - direct care staff wages or targeted service coordinator wages, employee-related expenses, program-related expenses, and general and administrative expenses. Each provider must demonstrate that the average percent of wage and benefits paid to their direct care staff (or targeted service coordinators) meets or exceeds the percent of wages and employee-related expenses utilized in establishing the reimbursement rate for the service type. The Department will utilize the reimbursement advisory workgroup established in this rule to collaboratively develop monitoring and enforcement procedures for this minimum allocation requirement. The cost components and new reimbursement rate are established in accordance with the following: (3-20-20)

a. Direct Care Staff Wages and Targeted Service Coordinator Wages. (3-20-20)

i. Direct care staff and targeted service coordinator wages are wages paid to individuals employed or contracted by an agency who perform duties described in the applicable service coverage description for at least seventy-five percent (75%) of the total annual amount of time they are compensated. (3-20-20)

ii. The wage component (Wage) used to establish the new reimbursement rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current Bureau of Labor and Statistics (BLS) State Occupational Employment and Wage Estimates table for the state of Idaho found on the BLS website at www.bls.gov. The BLS occupation profile that most closely aligns with the duties, education level, and supervision requirements of

the direct care staff (or targeted service coordinator) providing the service is utilized. If more than one (1) occupation profile aligns with the duties, education level, and supervision requirements of the direct care staff (or the targeted service coordinator) providing the service, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is utilized. (3-20-20)

iii. When there is no comparable occupation profile or profiles for the direct care staff (or targeted service coordinator), then the wage component used to establish the new reimbursement rate is set using the weighted average hourly rate (WAHR) of the surveyed wages included in the final cost survey results. (3-20-20)

iv. The Department will make the final determination of BLS occupation profile or profiles after consideration of advice from the relevant Reimbursement Advisory Workgroup. (3-20-20)

v. The Department will evaluate an appropriate wage inflation factor based on the economic data available at the time the reimbursement rate is set. (3-20-20)

b. Employee-Related Expenses (ERE). (3-20-20)

i. ERE are the expenses incurred by the provider agency for the benefit of the direct care staff (or targeted service coordinators) of an agency in the following six (6) categories: (1) paid leave, (2) supplemental pay, (3) payroll taxes, (4) workers' compensation, (5) insurance coverage, and (6) retirement contributions. (3-20-20)

ii. The ERE component percentage (ERE%) used to establish the new reimbursement rate is set using the cumulative percentage of employer costs for employee compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15. (3-20-20)

c. Program-Related Expenses (PRE). (3-20-20)

i. PRE are wages and other expenses that support the objectives and provision of the service but cannot be tied to any particular person receiving the service. Requirements related to the delivery of services in accordance with statute and rule are PRE. (3-20-20)

ii. Program-related staff are individuals employed by an agency who perform program-related duties as required by statute or rule for at least seventy-five percent (75%) of the total annual amount of time they are compensated. (3-20-20)

iii. Utilizing data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by the agency's total wages. Each agency's PRE% is ranked, and the PRE% used to calculate the new reimbursement rate is set at the mean of the agency PRE%. (3-20-20)

d. General and Administrative (G&A) Expenses. (3-20-20)

i. G&A expenses are wages and other expenses related to day-to-day operations common across all businesses. (3-20-20)

ii. G&A staff are individuals employed by an agency who perform administrative duties for at least seventy-five percent (75%) of the total annual amount of time they are compensated. (3-20-20)

iii. Utilizing data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus the total ERE, plus the total PRE, plus the total G&A expenses. Each agency's G&A% is ranked, and the G&A% used to calculate the new reimbursement rate is set at the mean of the agency G&A%. (3-20-20)

iv. The G&A% used to calculate the new reimbursement rate will not exceed ten percent (10%) of the total reimbursement rate per staff hour. (3-20-20)

e. Total Reimbursement Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) /(1- (G&A%)). (3-20-20)

f. The Department is not obligated to make budget requests based on the total reimbursement rate per staff hour. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates. Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature. (3-20-20)

05. Quality Performance Incentives. (3-20-20)

a. Based on the quality of services provided to its Medicaid participants, a provider may become eligible to receive incentive payments. (3-20-20)

b. Quality measures and associated payment percentages will be established by the Department, in collaboration with the Idaho Council on Developmental Disabilities and DisAbility Rights Idaho (or such other organization designated by the Governor as the state's protection and advocacy system), and will be described in the Idaho Medicaid Provider Handbook available at www.idmedicaid.com. The Department will provide sixty (60) days prior notice of any substantive changes to the quality measures and associated payment percentages described in its provider handbook. (3-20-20)

c. Incentive payments will be subject to the availability of State and federal funds, and may be rescinded if the quality of services declines. (3-20-20)

039. ACCOUNTING TREATMENT.
Generally accepted accounting principles, concepts, and definitions will be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be the one that most clearly attains program objectives. (3-19-07)

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. (3-4-11)

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. (3-19-07)

03. Other Actions. Generally, overpayment will result in two (2) circumstances: (3-19-07)

a. If the cost report is not filed, the sum of the following will be due: (3-19-07)

i. All payments included in the period covered by the missing report(s). (3-19-07)

ii. All subsequent payments. (3-19-07)

b. Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction will be designated to effect at least one (1) of the following: (3-19-07)

i. Discontinuance of overpayments (on an interim basis). (3-19-07)

ii. Recovery of overpayments. (3-19-07)

040. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.
The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Subsection 001.03 of these rules. (3-19-07)

01. Expenditure Documentation. Documentation of expenditures must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. (3-19-07)

02. Cost Allocation Process. Costs such as depreciation or amortization of assets and indirect expenses are allocated to activities or functions based on the original identity of the costs. Documentation to support

basis for allocation must be available for verification. (3-19-07)

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. (3-19-07)

04. Availability of Records. Records must be available for and subject to audit by the auditor, with or without prior notice, during any working day between the hours of 8:00 a.m. and 5:00 p.m. at the provider's principal place of business in the state of Idaho. (3-19-07)

a. The provider is given the opportunity to provide documentation before the interim final audit report is issued. (3-19-07)

b. The provider is not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. (3-19-07)

05. Retention of Records. Records required in Subsections 040.01 through 040.03 of these rules must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services. (3-19-07)

041. -- 049. (RESERVED)

050. DRAFT AUDIT REPORT.
Following completion of the audit field work on a hospital, nursing facility, or an ICF/ID, and before issuing the interim final audit report to the Department, the auditor will issue a draft audit report and forward a copy to the provider for review and comment. (3-19-07)

01. Review Period. The provider will have a period of sixty (60) days, beginning on the date of transmittal, to review and provide additional comments or evidence pertaining to the draft audit report. The review period may be extended when the provider: (3-19-07)

a. Requests an extension prior to the expiration of the original review period; and (3-19-07)

b. Clearly demonstrates the need for additional time to properly respond. (3-19-07)

02. Evaluation of Provider's Response. The auditor will evaluate the provider's response to the draft audit report and will delete, modify, or reaffirm the original findings, as deemed appropriate, in preparing the interim final audit report. (3-19-07)

051. FINAL AUDIT REPORT.
The auditor will incorporate the provider's response and an analysis of the response into the interim final report as appendices and transmit it to the Department. The Department will issue a final audit report and a notice of program reimbursement, if applicable, that sets forth settlement amounts due to the Department or the provider. The final audit report and notice of program reimbursement, if applicable, will take into account the findings made in the interim final audit report and the response of the provider to the draft audit report (3-19-07)

052. -- 059. (RESERVED)

060. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX AND TITLE XXI PROGRAMS.

01. Application for Participation and Reimbursement. Prior to participation in the Medical Assistance Program, facilities must be licensed or certified by the Department. The Department issues a provider number to the facility that becomes the primary provider identification number. The Division of Medicaid will establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. (3-20-20)

02. Reimbursement. The reimbursement mechanism for payment to provider facilities is specified in

IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. (3-19-07)

061. -- 069. (RESERVED)

070. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: (3-19-07)

01. Supplying Organization. That the supplying organization is a bona fide separate organization; (3-19-07)

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. (3-19-07)

03. Sales and Rental of Extended Care Facilities. The exception is not applicable to sales, lease or rentals of nursing homes or extended care facilities. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished. See PRM, Sections 1008 and 1012. (3-19-07)

a. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. (3-19-07)

b. When a facility is purchased from a related entity, the purchaser's depreciable basis will not exceed the seller's net book value. See PRM, Section 1005. (3-19-07)

071. -- 074. (RESERVED)

COVERED SERVICES
(Sections 075)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan are enrolled in all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." In addition to those benefits, individuals in the enhanced plan are eligible for enhanced benefits as described in this chapter of rules. (4-11-19)

076. MANAGED CARE FOR DUALS: DEFINITIONS.
For the purposes of the managed care service delivery system for dual eligible beneficiaries described in Sections 076 through 079 of these rules, the following definitions apply: (4-11-19)

01. Dual Eligible. A participant who is eligible for medical assistance under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The participant's Medicaid eligibility must not be based solely on the requirements found under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 802. In addition, the participant must be eligible for and enrolled in both Medicare Part A and Medicare Part B, and must not have Medicare eligibility due to End-Stage Renal Disease (ESRD). (4-11-19)

02. Health Plan. A health insurance company responsible for administering Medicaid benefits to dual eligible participants under a provider agreement with the Department. (4-11-19)

03. Idaho Medicaid Plus. A managed care program designed to administer Medicaid benefits for dual eligible participants administered under a provider agreement between the Department and participating health plans. (4-11-19)

04. Medicare/Medicaid Coordinated Plan. A managed care program as defined in IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." (4-11-19)

05. Passive Enrollment. An enrollment process in which a participant is assigned to a participating health plan in a managed care service delivery structure unless the participant actively opts out of the enrollment process. (4-11-19)

077. MANAGED CARE FOR DUALS: PROGRAM AUTHORITY AND IMPLEMENTATION.

01. Program Authority. Idaho Medicaid Plus is a managed care program for dual eligible participants administered with approval from the Centers for Medicare and Medicaid Services (CMS). The Idaho Medicaid Plus program allows for a health plan to administer Medicaid benefits to dual eligible participants. (4-11-19)

02. Implementation. Idaho Medicaid Plus will be implemented using a phased-in approach. (4-11-19)

a. Idaho Medicaid Plus will be implemented in a pilot county upon approval from CMS and after the Department determines that participating health plans have passed a readiness review for implementation. (4-11-19)

b. Implementation in additional counties will occur in a phased-in manner upon successful implementation in the pilot county as determined by the Department. Phased-in implementation in any and all additional counties will be subject to Department approval. (4-11-19)

c. Participating health plans must meet established performance benchmarks prior to Idaho Medicaid Plus implementation in each successive geographic service area. (4-11-19)

078. MANAGED CARE FOR DUALS: PARTICIPANT ELIGIBILITY AND ENROLLMENT.
Idaho Medicaid Plus will be made available to dual eligible participants over age twenty-one (21) who reside in a county with at least one (1) participating health plan. (4-11-19)

01. Excluded Populations. Idaho Medicaid Plus is not available to the following populations: (4-11-19)

a. Dual eligible participants that have elected to enroll in the Medicare Medicaid Coordinated Plan as defined in IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." (4-11-19)

b. Individuals who have Medicare eligibility related to End-Stage Renal Disease. (4-11-19)

c. Individuals enrolled in the Adult Developmental Disabilities 1915(c) waiver program as defined in Section 702 of these rules. (4-11-19)

02. Optional Populations. Tribal members and pregnant women who are dual eligible participants can elect to voluntarily enroll in Idaho Medicaid Plus if it is available in their county of residence. These participants retain the right to disenroll from Idaho Medicaid Plus at any time. (4-11-19)

03. Mandatory Enrollment. Dual eligible participants that are not members of an excluded population and reside in a county with two (2) or more participating health plans must select a health plan to administer their Idaho Medicaid Plus program. Mandatory enrollment procedures will occur in accordance with 42 CFR 438 Subpart B. (4-11-19)

04. Passive Enrollment. Dual eligible participants that are not members of an excluded population and reside in a county with only one (1) participating health plan will be enrolled into that health plan to administer their Idaho Medicaid Plus program unless they opt out by contacting the Department using the instructions on the enrollment notice. These dual eligible participants may opt out of Idaho Medicaid Plus at any time. (4-11-19)

079. MANAGED CARE FOR DUALS: COVERED SERVICES.

01. Coverage and Limitations. (4-11-19)

a. Idaho Medicaid Plus covered services include Medicaid benefits as described in this chapter and IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (4-11-19)

b. Services for adults with developmental disabilities as described in Sections 511, 580, and 703 of these rules are excluded from Idaho Medicaid Plus. (4-11-19)

c. Services administered under the managed care or brokerage contracts as described in Section 080 of these rules, and IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 870 through 872 are excluded from Idaho Medicaid Plus. (4-11-19)

02. Provider Reimbursement. Idaho Medicaid Plus participating health plans are required to reimburse network providers, at minimum, the established Medicaid fee schedule rates published on the Medicaid provider webpage and developed in accordance with Idaho Code and Department rule. (4-11-19)

080. -- 089. (RESERVED)

SUB AREA: ENHANCED HOSPITAL SERVICES
(Sections 090-099)

090. ORGAN TRANSPLANTS.
The Department will reimburse for organ transplant services as detailed in the Idaho Medicaid Provider Handbook, when medically necessary and provided by hospitals approved by the Centers for Medicare and Medicaid for the Medicare program that have completed a provider agreement with the Department. (7-1-19)

091. -- 092. (RESERVED)

093. ORGAN TRANSPLANTS: COVERAGE AND LIMITATIONS.

01. Coverage Limitations. No organ transplant will be covered by the Medical Assistance Program unless prior authorized by the Department, or its designee. Coverage is limited to organ transplants performed for the treatment of medical conditions in accordance with evidence-based standards of care. (7-1-19)

02. Living Donor Costs. The transplant costs for actual or potential living donors are fully covered by Medicaid and include all medically necessary preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. (7-1-19)

094. -- 095. (RESERVED)

096. ORGAN TRANSPLANTS: PROVIDER REIMBURSEMENT.
Organ transplant, procurement services, and follow-up care by facilities will be reimbursed as specified in the provider agreement. Reimbursement for organ procurement and histocompatibility laboratory tests will be made to the facility performing the transplant. (7-1-19)

097. -- 099. (RESERVED)

SUB AREA: ENHANCED INPATIENT BEHAVIORAL HEALTH SERVICES
(Sections 100-199)

100. INPATIENT BEHAVIORAL HEALTH SERVICES.
The Medicaid Enhanced Plan Benefits include psychiatric services covered under inpatient hospital services and inpatient behavioral health services covered in IDAPA 16.03.09 "Medicaid Basic Plan Benefits." (7-1-18)

101. INPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
The rules for Inpatient Behavioral Health Services are found in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 700 through 706 and apply to Inpatient Behavioral Health Services in these rules. Individuals over age sixty-five (65) are eligible for inpatient behavioral health services under these rules. (3-20-20)

102. -- 199. (RESERVED)

SUB AREA: ENHANCED HOME HEALTH CARE
(Sections 200-214)

200. PRIVATE DUTY NURSING SERVICES.

01. Description of Private Duty Nursing Services. Private Duty Nursing (PDN) services are nursing services provided by a licensed registered nurse or licensed practical nurse to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. Sections 200 through 209 of these rules cover requirements for private duty nursing services. (3-13-20)T

02. Temporary Changes to Private Duty Nursing Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PDN services in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver through the duration of the emergency state. (3-13-20)T

201. PRIVATE DUTY NURSING: DEFINITIONS.
The following definitions apply to Sections 200 through Section 209 of these rules. (3-19-07)

01. Primary RN. The RN identified by the family to be responsible for development, implementation, and maintenance of the Medical Plan of Care. (3-19-07)

02. Private Duty Nursing (PDN) RN Supervisor. An RN providing oversight of PDN services delegated to LPN's providing the child's care, in accordance with IDAPA 23.01.01, "Rules of the Board of Nursing." (3-19-07)

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 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 Services along with other community resources are not sufficient to ensure the health or safety of the child. (3-19-07)

210. - 214. (RESERVED)

SUB AREA: THERAPIES
(Sections 215-219)

215. - 219. (RESERVED)

SUB AREA: LONG-TERM CARE
(Sections 220-330)

220. NURSING FACILITY.
The Enhanced Plan Benefit includes nursing facilities services permitted under Section 1905(a)(4)(A) of the Social Security Act. These services include nursing facilities services (other than services in an institution for mental diseases) for individuals determined to be in need of such care. (3-19-07)

221. (RESERVED)

222. NURSING FACILITY SERVICES: ELIGIBILITY.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Department has determined that the individual meets the criteria for nursing facility services. Entitlement will be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (4-2-08)

01. Criteria for Determination. The criteria for determining a medical assistance participant's need for nursing facility care is described in Section 223. In addition, the Inspection of Care/Utilization Control (IOC/UC) nurse must determine whether a medical assistance participant's needs could be met by alternatives other than residing in a nursing facility, such as an independent living arrangement or residing in a room and board situation. (3-19-07)

a. The participant can select any certified facility to provide the care required. (3-19-07)

b. The final decision as to the level of care required by a medical assistance participant must be made by the IOC/UC Nurse. (3-19-07)

c. The final decision as to the need for developmental disability (DD) or mental illness (MI) active treatment will be made by the appropriate Department staff as a result of the Level II screening process. (3-19-07)

d. No payment will be made by the Department on behalf of any eligible medical assistance participant to any long-term care facility that, in the judgment of the IOC/UC Team, is admitting individuals for care or services that are beyond the facility's licensed level of care or capability. (3-19-07)

02. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field Office will forward to such facility an “Authorization for Long-Term Care Payment” form HW 0459. (3-19-07)

223. NURSING FACILITY: CRITERIA FOR DETERMINING NEED.
The participant requires nursing facility level of care when an adult meets one (1) of the Resource Utilization Group (RUG III) classifications or when a child meets one (1) or more of the criteria described in Subsections 223.02, 223.03, 223.04 or 223.05 of this rule. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years of age. (4-2-08)

01. Required Assessment for Adults. A standard assessment will be approved by the Department for

all adults requesting services with requirements for nursing facility level of care. The Department will specify the instrument to be used. (4-2-08)

02. Supervision Required for Children. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. (3-19-07)

03. Preventing Deterioration for Children. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. (3-19-07)

04. Specific Needs for Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. (3-19-07)

05. Nursing Facility Level of Care for Children. Using the criteria found in Subsections 223.02, 223.03, and 223.04 of these rules, plus consideration of the developmental milestones, based on the age of the child, the Department's BLTC will determine nursing facility level of care. (3-20-20)

06. Conditions of Payment. (3-19-07)

a. As a condition of payment by the Department for long-term care on behalf of medical assistance participants, each fully licensed long-term care facility is to be under the supervision of an administrator who is currently licensed under the laws of the state of Idaho and in accordance with the rules of the Bureau of Occupational Licenses. (3-19-07)

b. Payment by the Department for the cost of long-term care excludes the date of the participant's discharge, unless the day of discharge occurs on the same day as admission; then, one (1) day of care is deemed to exist. When a Medicaid patient dies in a nursing home, the date of death is covered, regardless of the time of death. (3-21-12)

224. NURSING FACILITY: POST-ELIGIBILITY TREATMENT OF INCOME.
Where an individual is determined eligible for medical assistance participation in the cost of their long term care, the Department will reduce its payment to the long term care facility by the amount of their income considered available to meet the cost of their care. This determination is made in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Sections 721 through 726. The amount that the medical assistance participant receives from SSA as reimbursement for their payment of the premium for Part B of Title XVIII (Medicare) is not considered income for patient liability under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD),**"** Section 317. (3-19-07)

225. NURSING FACILITY: COVERAGE AND LIMITATIONS.
An institution must provide, on a regular basis, health-related care and services to individuals; who because of their mental or physical condition require care and services above the level of room, board, and supervision. (3-19-07)

01. Nursing Facility Care. The minimum content of care and services for nursing facility patients must include the following: (3-19-07)

a. Room and board; (3-19-07)

b. Bed and bathroom linens; (3-19-07)

c. Nursing care, including special feeding if needed; (3-19-07)

d. Personal services; (3-19-07)

e. Supervision as required by the nature of the patient's illness and duration of their stay in the nursing

facility; (3-4-11)

f. Special diets as prescribed by a patient's physician; (3-19-07)

g. All common medicine chest supplies that are over-the-counter including mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; (3-4-11)

h. Dressings; (3-19-07)

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (3-19-07)

j. Application or administration of all drugs; (3-19-07)

k. All medical supplies including gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton, incontinent supplies, or any other type of pads used to save labor or linen, and disposable gloves; (3-20-20)

l. Social and recreational activities; and (3-19-07)

m. Each item that is utilized by individual patients and is reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (3-4-11)

02. Skilled Services. Skilled services include services that could qualify as either skilled nursing or skilled rehabilitative services, that include: (3-19-07)

a. Overall management and evaluation of the care plan. The development, management, and evaluation of a resident's care plan, based on the physician's orders, constitute skilled services when, in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet their needs, promote their recovery, and assure their medical safety. This would include the management of a plan involving only a variety of personal care services where, in light of the patient's condition, the aggregate of such services necessitates the involvement of technical or professional personnel. Where the patient's overall condition would support a finding that their recovery and safety could be assured only if the total care they require is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided. (3-19-07)

b. Observation and assessment of the resident's changing condition. When the resident's condition is such that the skills of a licensed nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until their condition is stabilized, such services constitute skilled services. (3-19-07)

03. Direct Skilled Nursing Services. Direct skilled nursing services include the following: (3-19-07)

a. Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; (3-19-07)

b. Nasopharyngeal feedings; (3-19-07)

c. Nasopharyngeal and tracheotomy aspiration; (3-19-07)

d. Insertion and sterile irrigation and replacement of catheters; (3-19-07)

e. Application of dressings involving prescription medications or aseptic techniques; (3-19-07)

f. Treatment of extensive decubitus ulcers or other widespread skin disorders; (3-19-07)

g. Heat treatments that have been specifically ordered by a physician as part of treatment and that require observation by nurses to adequately evaluate the resident's progress; and (3-19-07)

h. Initial phases of a regimen involving administration of oxygen. (3-19-07)

04. Direct Skilled Rehabilitative Services. Direct skilled rehabilitative services include the following: (3-19-07)

a. Ongoing assessment of rehabilitation needs and potential, services concurrent with the management of a resident's care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; (3-19-07)

b. Therapeutic exercises or activities that, because of the type of exercises employed or the condition of the resident, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the resident and the effectiveness of the treatment; (3-19-07)

c. Gait evaluation and training furnished by a physical or occupational therapist to restore function in a resident whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and (3-19-07)

d. Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist. (3-19-07)

05. Other Treatment and Modalities. Other treatment and modalities that include hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool, in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgement of a licensed physical therapist are required. (3-19-07)

226. NURSING FACILITY: PROCEDURAL RESPONSIBILITIES.

01. Nursing Facility Responsibility. Each nursing facility administrator, or their authorized representative must report the following information to the appropriate BLTC within three (3) working days of the date the facility has knowledge of the following. (3-20-20)

a. Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. (3-19-07)

b. Any changes in the amount of a participant's income. (3-19-07)

c. When a participant's account has exceeded the following amount; (3-19-07)

i. For a single individual, one thousand eight hundred dollars ($1,800);or (3-19-07)

ii. For a married couple, two thousand eight hundred dollars ($2,800). (3-19-07)

02. Other Financial Information for Participant. Other information about a participant's finances that may potentially affect eligibility for medical assistance must be reported if the nursing facility has any knowledge of the participant’s financial information. (3-19-07)

227. PREADMISSION SCREENING AND RESIDENT REVIEW PROGRAM (PASRR).
All Medicaid certified nursing facilities must participate in, cooperate with, and meet all requirements imposed by, the Preadmission Screening and Resident Review program, (PASRR) as set forth in 42 CFR, Part 483, Subpart C. (3-20-20)

01. Background and Purpose. The purpose of these provisions is to comply with and implement the PASRR requirements imposed on the state by federal law. The purpose of those requirements is to prevent the

placement of individuals with mental illness (MI) or intellectual disabilities (ID) in a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. This is accomplished by both pre-admission screening (PAS) and resident review (RR). Individuals, for whom it appears that a diagnosis of MI or ID is likely, are identified for further screening by means of a Level I screen. The actual PASRR is accomplished through a Level II screen where it is determined whether, because of the individual's physical and mental condition, they require the level of services provided by a nursing facility. If the individual with MI or ID is determined to require a nursing facility level of care, it must also be determined whether the individual requires specialized services. PASRR applies to all individuals entering or residing in a nursing facility, regardless of payment source. (3-20-20)

02. Policy. It is the policy of the Department that the difficulty in providing specialized services in the nursing facility setting makes it generally inappropriate to place individuals needing specialized services in an nursing facility. This policy is supported by the background and development of the federal PASRR requirements, including the narrow definition of mental illness adopted by federal law. While recognizing that there are exceptions, it is envisioned that most individuals appropriate for nursing facility placement will not require services in excess of those required to be provided by nursing facilities by 42 CFR 483.45. (3-19-07)

03. Inter-Agency Agreement. The state Medicaid agency will enter into a written agreement with the state mental health and intellectual disabilities authorities as required in 42 CFR 431.621(c). This agreement will, among other things, set forth respective duties and delegation of responsibilities, and any supplemental criteria to be used in making determinations. (3-19-07)

a. The "State Mental Health Authority" (SMHA) in the Division of Behavioral Health of the Department, or its successor entity. (3-20-20)

b. The "State Intellectual Disabilities or Developmental Disabilities Authority" (SDDA) in the Division of Family and Community Services of the Department, or its successor entity. (3-19-07)

04. Coordination for PASRR. The PASRR process is a coordinated effort between the state Medicaid agency, the SMHA and SDDA, independent evaluators and the nursing facility. PASRR activities will be coordinated through the Bureau of Long Term Care (BLTC). BLTC is responsible for record retention and tracking functions. However, the nursing facility is responsible for assuring that all screens are obtained and for coordination with the BLTC, independent MI evaluators, the SMHA and SDDA, and their designees. (3-20-20)

a. All required Level I screens and reviews must be completed and submitted to the BLTC prior to admission to the facility. (3-20-20)

b. When a nursing facility identifies an individual with MI or ID through a Level I screen, or otherwise, the nursing facility is responsible for contacting the SMHA or SDDA (as appropriate), and assuring that a Level II screen is completed prior to admission to the facility, or in the case of an existing resident, completed in order to continue residing in the facility. (3-19-07)

c. Resident Reviews (RR). An individual identified with MI or ID must be reviewed and a new determination made promptly after a significant change in their physical or mental condition. The facility must notify the BLTC of any such change within two (2) working days of its occurrence. For the purpose of this section, significant change for the participant's mental condition means a change that may require the provision of specialized services or an increase in such services. A significant change in physical condition is a change that renders the participant incapable of responding to MI or D.D. program interventions. (3-20-20)

228. NURSING FACILITY: COORDINATION OF NURSING FACILITY ELIGIBILITY AND THE NEED FOR SPECIALIZED SERVICES.

Determinations as to the need for nursing facility care and determinations as to the need for specialized services should not be made independently. Such determinations will often be made on an individual basis, taking into account the condition of the resident and the capability of the facility to which admission is proposed to furnish the care needed. When an individual identified with MI and ID is admitted to a nursing facility, the nursing facility is responsible for meeting that individual's needs, except for the provision of specialized services. (3-19-07)

01. Level of Care. (3-19-07)

a. Individual determinations must be based on evaluations and data as required by these rules. (3-19-07)

b. Categorical determinations. Recognizing that individual determinations of level of care are not always necessary, those categories set forth as examples at 42 CFR 483.130(d) are hereby adopted as appropriate for categorical determinations. When nursing facility level of care is determined appropriate categorically, the individual may be conditionally admitted prior to completion of the determination for specialized services. However, conditional admissions cannot exceed seven (7) days, except for respite admissions which cannot exceed thirty (30) consecutive days in one (1) calendar year. (3-19-07)

02. Specialized Services. Specialized services for mental illness as defined in 42 CFR 483.120(a)(1), and for intellectual disabilities as defined in 42 CFR 483.120(a)(2), are those services provided by the state that due to the intensity and scope can only be delivered by personnel and programs that are not included in the specialized rehabilitation services required of nursing facilities under 42 CFR 483.45. The need for specialized services must be documented and included in both the resident assessment instrument and the plan of care. (3-19-07)

a. Individual determinations must be based on evaluations and data as required by these rules. (3-19-07)

b. Categorical determinations that specialized services are not needed may be made in those situations permitted by 42 CFR 483.130. (3-19-07)

03. Penalty for Non-Compliance. No payment will be made for any services rendered by a nursing facility prior to completion of the Level I screen and, if required, the Level II screen. Failure to comply with PASRR requirements for all individuals admitted or seeking admission may also subject a nursing facility to other penalties as part of certification action under 42 CFR 483.20. (3-19-07)

04. Appeals. Discharges, transfers, and preadmission PASRR determinations may be appealed to the extent required by 42 CFR, Part 483, Subpart E, and under Section 67-5229, Idaho Code. Appeals under this paragraph are made in accordance with the fair hearing provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-19-07)

a. A Level I finding of MI or ID is not an appealable determination. It may be disputed as part of a Level II determination appeal. (3-19-07)

b. In the event that the PASRR program is eliminated or made non-mandatory by an act of Congress, the provisions of Section 227 of these rules will cease to be operative on the effective date of any such act, without further action. (3-19-07)

229. NURSING FACILITY: PREPAYMENT SCREEN AND DETERMINATION OF ENTITLEMENT TO MEDICAID PAYMENT FOR NURSING FACILITY CARE AND SERVICES.
The level of care for Title XIX and Title XXI payment purposes is determined by the Department. Necessity for payment is determined in accordance with 42 CFR 483 Subpart C and Section 1919(e) (7) of the Social Security Act. In the event a required Level II screen was not accomplished prior to admission, entitlement for Medicaid payment as established by the BLTC will not be earlier than the date the Level II screen is completed, indicating that nursing facility placement is appropriate. (3-20-20)

01. Information Required for Medical Evaluation Determination. A current Minimum Data Set (MDS) assessment will be provided to the Department. Additional supporting information may be requested. (3-19-07)

02. Information Required for Level I and II Screen Determination. An accurate Level I screen and when required, a Level II screen. (3-19-07)

230. NURSING FACILITY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as a nursing facility. (3-19-07)

02. Licensure and Certification. (3-19-07)

a. Upon receipt of an application from a facility, the Licensing and Certification Agency determines the facility's compliance with certification standards for the type of care the facility proposes to provide to medical assistance participants. (3-19-07)

b. If a facility proposes to participate as a skilled nursing facility, Medicare (Title XVIII) certification and program participation is required before the facility can be certified for Medicaid. The Licensing and Certification Agency will determine the facility's compliance with Medicare requirements and recommend certification to the Medicare Agency. (3-19-07)

c. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for nursing facility care. The Department will certify to the appropriate branch of government that the facility meets the standards for nursing facility level of care. (3-19-07)

d. Upon receipt of the certification from the Licensing and Certification Agency, the Department may enter into a provider agreement with the long-term care facility. (3-19-07)

e. After the provider agreement has been executed by the Facility Administrator and by the Department, one (1) copy will be sent by certified mail to the facility and the original is to be retained by the Department. (3-19-07)

231. -- 234. (RESERVED)

235. NURSING FACILITY: PROVIDER REIMBURSEMENT.

01. Payment Methodology. Nursing facilities will be reimbursed in accordance with the payment methodologies as described in Sections 236 through 295 of these rules. (3-19-07)

02. Date of Discharge. Payment by the Department for the cost of long term care is to exclude the date of the participant's discharge. If a Medicaid patient dies in a nursing home, their date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. (3-21-12)

236. NURSING FACILITY: REASONABLE COST PRINCIPLES.
To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to participants will result. (3-19-07)

01. Application of Reasonable Cost Principles. (3-19-07)

a. Reasonable costs of any services are determined in accordance with this chapter of rules found in Sections 236 through 295 of these rules, and Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (3-19-07)

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (3-19-07)

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (3-19-07)

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Idaho Code, or are unallowable by application of promulgated regulation. (3-19-07)

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (3-19-07)

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (3-19-07)

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. (3-20-20)

03. Costs Not Related to Patient Care. Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. (3-20-20)

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. (3-20-20)

237. NURSING FACILITY: NOTICE OF PROGRAM REIMBURSEMENT.
Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider that sets forth the amounts of underpayment or overpayment made to the provider. (3-19-07)

01. Notice. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. (3-19-07)

02. Recovery or Suspension. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. (3-19-07)

03. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary. (3-19-07)

04. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three-year (3) period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. (3-19-07)

238. NURSING FACILITY: INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS.
The Title XIX and Title XXI programs will charge interest on overpayments, and pay interest on underpayments. (3-19-07)

01. Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement, and will be charged on the unpaid settlement balance for each

thirty- day (30) period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty-day (30) period, and the thirty-day (30) interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. (3-19-07)

02. Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. (3-19-07)

03. Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly. (3-19-07)

04. Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes that occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only be applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. (3-19-07)

239. NURSING FACILITY: RECOVERY METHODS FOR OVERPAYMENTS.
One (1) of the following methods will be used for recovery of overpayments: (3-19-07)

01. Lump Sum Voluntary Repayment. Upon receipt of the notice of program reimbursement, the provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. (3-19-07)

02. Periodic Voluntary Repayment. The provider must request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. (3-19-07)

03. Department Initiated Recovery. The Department will recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice. (3-19-07)

04. Recovery From Medicare Payments. The Department can request that Medicare payments be withheld in accordance with 42 CFR, Section 405.377. (3-19-07)

240. NURSING FACILITY: ALLOWABLE COSTS.
The following definitions and explanations apply to allowable costs: (3-19-07)

01. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable. (3-19-07)

02. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement cannot exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee. (3-19-07)

03. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable under PRM, Section 300. (3-19-07)

04. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (3-19-07)

05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must

be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section 274 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (3-19-07)

a. Salaries wages, bonuses and benefits that are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (3-19-07)

b. Supplies and services provided for the owner's personal use. (3-19-07)

c. Compensation paid by the facility to employees for the sole benefit of the owner. (3-19-07)

d. Fees for consultants, directors, or any other fees paid regardless of the label. (3-19-07)

e. Keyman life insurance. (3-19-07)

f. Living expenses, including those paid for related persons. (3-19-07)

06. Contracted Service. All services that are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (3-19-07)

07. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Section 275 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (3-19-07)

08. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met. (3-19-07)

09. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (3-19-07)

10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable. (3-19-07)

11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment. (3-19-07)

12. Food. Costs of raw food are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food. (3-20-20)

13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers. (3-19-07)

14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. (3-19-07)

15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (3-19-07)

16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices cannot be reported as property costs, but will be allowable based on reasonable cost principles subject to other limitations contained herein. (3-19-07)

17. Malpractice and Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs. (3-19-07)

18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable. (3-19-07)

19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For free-standing nursing facilities, the property rental rate is paid as described in Section 275 of these rules. Hospital-based nursing facilities are paid based on property costs. (3-19-07)

a. Amortization of leasehold improvements will be included in property costs. (3-19-07)

i Straight line depreciation on fixed assets is included in property costs. (3-19-07)

ii. Depreciation of moveable equipment is an allowable property cost. (3-19-07)

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities. (3-19-07)

20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (3-19-07)

21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (3-19-07)

22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost. (3-19-07)

23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable. (3-19-07)

24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs. (3-19-07)

241. NURSING FACILITY: NONALLOWABLE COSTS.
The following definitions and explanations apply to nonallowable costs: (3-19-07)

01. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable. (3-19-07)

02. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable. (3-19-07)

03. Barber and Beauty Shops. All costs related to running barber and beauty shops are nonallowable. (3-19-07)

04. Charity Allowances. Cost of free care or discounted services are nonallowable. (3-19-07)

05. **Fees**. Franchise fees are nonallowable, see PRM, Section 2133.1. (3-19-07)

06. **Fund Raising**. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2. (3-19-07)

07. **Goodwill**. Costs associated with goodwill as defined in Section 011 of these rules are nonallowable. (3-19-07)

08. **Holding Companies**. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A. (3-19-07)

09. **Interest**. Interest to finance nonallowable costs are nonallowable. (3-19-07)

10. **Medicare Costs**. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. (3-19-07)

11. **Nonpatient Care Related Activities**. All activities not related to patient care are nonallowable. (3-19-07)

12. **Organization**. Organization costs are nonallowable, see PRM, Section 2134. (3-19-07)

13. **Pharmacist Salaries**. Salaries and wages of pharmacists are nonallowable. (3-19-07)

14. **Prescription Drugs**. Prescription drug costs are nonallowable. (3-19-07)

15. **Related Party Interest**. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2. (3-19-07)

16. **Related Party Nonallowable Costs**. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated. (3-19-07)

17. **Related Party Refunds**. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (3-19-07)

18. **Self-Employment Taxes**. Self-employment taxes, as defined by the Internal Revenue Service, that apply to facility owners are nonallowable. (3-19-07)

19. **Telephone Book Advertising**. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. (3-19-07)

20. **Vending Machines**. Costs of vending machines and cost of the product to stock the machine are nonallowable costs. (3-19-07)

242. NURSING FACILITY: HOME OFFICE COST PRINCIPLES.
The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, will provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (3-19-07)

243. NURSING FACILITY: RELATED PARTY TRANSACTIONS.

01. **Principle**. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (3-19-07)

02. **Cost Allowability - Regulation**. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM

Chapter 10 and other applicable chapters of the PRM. (3-19-07)

244. NURSING FACILITY: APPLICATION OF RELATED PARTY TRANSACTIONS.

01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (3-19-07)

a. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (3-19-07)

b. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control that is decisive, not its form or the mode of its exercise. (3-19-07)

02. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (3-19-07)

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the program. (3-19-07)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics. (3-19-07)

245. NURSING FACILITY: COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (3-19-07)

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (3-19-07)

a. Where such persons perform services without pay, no cost may be imputed. (3-19-07)

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (3-19-07)

c. Compensation for undocumented hours worked will not be a reimbursable cost. (3-19-07)

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: (3-19-07)

a. Husband or wife; (3-19-07)

b. Son or daughter or a descendant of either; (3-19-07)

c. Brother, sister, stepbrother, stepsister or descendant thereof; (3-19-07)

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (3-19-07)

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (3-19-07)

f. A descendant of a brother or sister of the provider's father or mother; (3-19-07)

g. Any other person with whom the provider does not have an arms length relationship. (3-19-07)

246. NURSING FACILITY: INTEREST EXPENSE.
Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (3-19-07)

247. -- 249. (RESERVED)

250. NURSING FACILITY: COST LIMITS.
Sections 250 through 271 of these rules, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56-135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999, are subject to rules in effect before July 1, 1999. (3-19-07)

251. (RESERVED)

252. NURSING FACILITY: PROPERTY AND UTILITY COSTS.
Whether or not each of these cost items is allowed will be determined in accordance with other provisions of this chapter, or the PRM in those cases where this the rules of this chapter are silent or not contradictory. Total property and utility costs are defined as being made up of the following cost categories. The Department may require and utilize an appraisal to establish those components of property costs that are identified as an integral part of an appraisal. (3-19-07)

01. **Depreciation**. All allowable depreciation expense. (3-19-07)

02. **Interest**. All allowable interest expense relating to financing building and equipment purchases. (3-20-20)

03. **Property Insurance**. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances will not be considered to be property costs. (3-19-07)

04. **Lease Payments**. All allowable lease or rental payments. (3-19-07)

05. **Property Taxes**. All allowable property taxes. (3-19-07)

06. **Utility Costs**. All allowable expenses for heat, electricity, water and sewer. (3-19-07)

253. -- 254. (RESERVED)

255. NURSING FACILITY: RATE SETTING.
The objectives of the rate setting mechanism for nursing facilities are: (3-19-07)

01. **Payments**. To make payments to nursing facilities through a prospective cost-based system, which includes facility-specific case mix adjustments. (3-19-07)

02. **Rate Adjustment**. To set rates based on each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents as of a certain date during the preceding quarter. (3-19-07)

256. NURSING FACILITY: PRINCIPLE FOR RATE SETTING.
Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs. (3-19-07)

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. The rate for a nursing facility is the sum of the cost components described in

Subsection 257.04 through 257.08 of this rule. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. For the rate year of July 1, 2011, through June 30, 2012, rates will be calculated using audited cost reports ended in calendar year 2010 with no allowance for inflation to the rate year of July 1, 2011, through June 30, 2012. For the rate years beginning July 1, 2012, and annually thereafter, rates will be calculated using audited cost reports for periods ended in the preceding calendar year with no allowance for inflation to the prospective rate period. (4-4-13)

01. Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the most recent assessment for each Medicaid resident in the nursing facility on the first day of the month of the preceding quarter (for example, assessments as of April 1are used to establish the CMI needed to establish rates for the quarter beginning July 1st). Facility-wide CMI is calculated based on the most recent assessment for all residents in the nursing facility. The CMI is recalculated quarterly and each nursing facility's rate is adjusted accordingly. A facility-wide CMI is also established each year by averaging four (4) calendar quarter CMIs for the cost reporting period from historical data to represent each fiscal quarter in the cost reporting period (for example, an October 1 CMI would represent the fiscal quarter ended September 30th). (3-19-07)

02. Applicable Cost Data. The cost data used in establishing the cost components of the rate calculation are from the audited or unaudited cost report that ended during the previous calendar year (for example, cost reports ending during the period from January 1, 1998 - December 31, 1998 are used in setting rates effective July 1, 1999). The draft audit of a cost report submitted by a facility will be issued by the Department no later than five (5) months after the date all information required for completion of the audit is filed with the Department. (3-19-07)

03. Interim Rates. Nursing facilities with unaudited cost reports are given an interim rate established by the Department until a rate is calculated based on an audited cost report. When audited data are available, a retroactive adjustment to the payment rate is made through the calculation of the finalized rate. (3-19-07)

04. Direct Care Cost Component. The direct care cost component of a nursing facility's rate is determined as follows: (3-19-07)

a. The direct care per diem cost limit applicable to the rate period for a nursing facility type (free-standing and urban hospital-based nursing facility, rural hospital-based nursing facility, free-standing and urban hospital-based behavioral care unit, or rural hospital-based behavioral care unit) is identified. The identified direct care cost limit is divided by the statewide average CMI for the cost reporting period, and then multiplied by the nursing facility's facility-wide CMI for the cost reporting period to derive the adjusted direct care per diem cost limit. (4-4-13)

b. The adjusted direct care per diem cost limit is compared to the nursing facility's inflated direct care per diem costs. The lower of the two (2) amounts is then case mix adjusted. (3-19-07)

i. If the adjusted direct care per diem cost limit is lower, the adjusted limit is divided by the nursing facility's facility-wide CMI for the cost reporting period, and then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period to arrive at the direct care cost component. (3-19-07)

ii. If the inflated direct care per diem costs are lower, these costs, minus raw food and Medicaid related ancillary costs, are divided by the nursing facility's facility-wide CMI for the cost reporting period, then multiplied by the nursing facility's most recent quarterly Medicaid CMI for the rate period. Raw food and Medicaid related ancillary costs are then added back to arrive at the direct care cost component. (3-19-07)

05. Indirect Care Cost Component. The indirect care cost component of a facility's rate is the lesser of the facility's inflated indirect care per diem costs, or the indirect per diem cost limit for that type of provider -- free-standing and urban hospital-based nursing facilities including behavioral care unit nursing facility providers, or rural hospital-based nursing facilities including behavioral care unit nursing facility providers. (4-4-13)

06. Costs Exempt From Limitation. Costs exempt from cost limits are property taxes, property insurance, utilities and costs related to new legal mandates as defined in Section 264 of these rules. (3-19-07)

07. Property Reimbursement. The property reimbursement component is calculated in accordance with Section 275 and Subsection 240.19 of these rules. (3-19-07)

08. Revenue Offset. Revenues from products or services provided to nonpatients will be offset from the corresponding rate component(s) as described in Section 257 of this rule. (4-4-13)

258. NURSING FACILITY: COST LIMITS BASED ON COST REPORT.
Each July 1st cost limitations will be established for nursing facilities based on the most recent audited cost report with an end date of June 30th of the previous year or before. Calculated limitations will be effective for a one (1) year period, from July 1 through June 30th of each year, which is the rate year. For the rate year of July 1, 2011, through June 30, 2012, the direct and indirect cost limits were calculated using the most recent audited cost reports adjusted to the midpoint of the cost reporting year's end in calendar year 2010, to allow for no inflation to the rate year. For rate years beginning July 1, 2012, and annually thereafter, the direct and indirect cost limits will be calculated using the most recent audited cost reports adjusted to the midpoint of each provider's cost reporting year that is used to set the July 1 rate, to allow for no inflation to the rate year. (4-4-13)

01. Percentage Above Bed-Weighted Median. (4-4-13)

a. Prior to establishing the first "shadow rates" at July 1, 1999, the estimated Medicaid payments under the previous retrospective system for the year period from July 1, 1999, through June 30, 2000, will be calculated. This amount will then be used to model the estimated payments under the case mix system set forth in Sections 255 through 257 of these rules. The percentages above the bed-weighted median, for direct and indirect costs, will be established at a level that approximates the same amount of Medicaid expenditures as would have been produced by the retrospective system. The percentages will also be established to approximate the same distribution of total Medicaid dollars between the hospital-based and freestanding nursing facilities as existed under the retrospective system. (4-4-13)

b. Once the percentage is established, it will be used to calculate the limit by multiplying the bed-weighted median per diem direct cost times the calculated percentage for that class of provider. There will be a direct and indirect percentage that is applied to freestanding and urban hospital-based nursing facilities, and a higher direct and indirect percentage that is applied to rural hospital-based nursing facilities. (4-4-13)

c. Beginning with rates effective October 1, 2012, additional direct care cost limit categories will be added for free-standing and urban hospital-based behavioral care units and rural hospital-based behavioral care units. Percentages previously established for other provider class types not considered a behavioral care unit will remain unchanged. Once established, these percentages will remain in effect for future rate setting periods. (4-4-13)

02. Direct Cost Limits. The direct cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be normalized and arrayed from high to low, with all nursing facilities included in the same array, and the bed-weighted median will be computed. (4-4-13)

03. Indirect Cost Limits. The indirect cost limitation will be calculated by indexing the selected cost data forward by the inflation adjustment from the midpoint of the cost report period to the midpoint of the period for which the limit will be applicable. The indexed per diem costs will then be arrayed, with all nursing facilities included in the same array, and the bed-weighted median will be computed. (4-4-13)

04. Limitation on Increase or Decrease of Cost Limits. Increases in the direct and indirect cost limits will be determined by the limitations calculated in the most recent base year, indexed forward each year from the midpoint of the base year to the midpoint of the rate year by the inflation factor plus one percent (1%) per annum. The calculated direct and indirect cost limits will not be allowed to decrease below the limitations effective in the base year. The maximum rate of growth on the cost limits, and the minimum cost limitation, will be examined by the oversight committee periodically to determine which factors to use in the calculation of the limitations effective in the new base year and forward. (3-29-10)

05. Costs Exempt From Limitations. Costs exempt from limitations include property taxes, property

insurance, and utilities. These costs will be reimbursed on a per diem basis and will not be included in the calculation of the direct or indirect care component. However, property taxes and property insurance will be subject to minimum occupancy levels as defined in Section 278 of these rules. (3-19-07)

259. NURSING FACILITY: TREATMENT OF NEW BEDS.
Facilities that add beds after July 1, 1999, will have their reimbursement rate subjected to an additional limitation for the next three (3) years. This limitation will apply beginning with the first rate setting period that utilizes a cost report that includes the date when the beds were added. (3-19-07)

01. Limitation of Facilities Rate. The facility's rate will be limited to the bed-weighted average of the following two (2) rates: (3-19-07)

a. The facility's current prospective rate calculated in accordance with Section 257 of these rules; and (3-19-07)

b. The current median rate for nursing facilities of that type, free-standing, rural hospital-based, or urban hospital-based, established each July 1st. (3-19-07)

02. Calculation of the Bed-Weighted Average. The current calculated facility rate is multiplied by the number of beds in existence prior to the addition. The median rate is multiplied by the number of added beds, weighted for the number of days in the cost reporting period for which they were in service. These two (2) amounts are added together and divided by the total number of beds, with the new beds being weighted if they were only in service for a portion of the year. The resulting per diem amount represents an overall limitation on the facility's reimbursement rate. Providers with calculated rates that do not exceed the limitation receive their calculated rate. (3-19-07)

03. Exception to New Bed Rate. The following situations will not be treated as new beds for reimbursement purposes: (3-19-07)

a. Any beds converted from nursing facility beds to assisted living beds, can be converted back to nursing facility beds within three (3) years and not be classified as new nursing facility beds. When a nursing facility bed has been converted to an assisted living bed for three (3) or more concurrent years and the bed is converted back to a nursing facility bed, it must be treated as a new nursing facility bed. (3-19-07)

b. Beds added as a result of expansion plans, that the Department was aware of prior to July 1, 1999, will not be treated as new beds. The facility must have already expended significant resources on the purchase of land, site planning, site utility planning, and development. The existence of adequate land or space at the nursing facility does not by itself constitute a significant expenditure of resources for the purposes of expansion. A written request with adequate supporting documentation for an exception under this provision must have been received by the Department no later than December 31, 1999. In no case will beds added after July 1, 2003, qualify for this exception to the new bed criteria. (3-19-07)

c. Beds that are decertified as a requirement of survey and certification due to deficiencies at the facility can be re-certified as existing beds with the approval of the Department. (3-19-07)

d. When a facility can demonstrate to the Department that adding beds is necessary to meet the needs of an under served area, these beds will not be treated as new beds. For an existing facility the new beds are reimbursed at the same reimbursement rate for that facility's existing beds. For a new facility, the reimbursement rate is negotiated with the Department. (3-19-07)

260. NURSING FACILITY: TREATMENT OF NEW FACILITIES.
Facilities constructed subsequent to July 1, 1999, will be reimbursed at the median rate for skilled care facilities of that type (freestanding or hospital-based) for the first three (3) full years of operation. During the period of limitation, the facility's rate will be modified each July 1st to reflect the current median rate for skilled care facilities of that type. After the first three (3) full years, the facility will have its rate established at the next July 1st with the existing facilities in accordance with Section 257 of this rule. (3-19-07)

261. NURSING FACILITY: TREATMENT OF A CHANGE IN OWNERSHIP.

New providers resulting from a change in ownership of an existing facility will receive the previous owner's rate until such time as the new owner has a cost report that qualifies for the rate setting criteria established under these rules. If the Department determines that such a facility is operationally or financially unstable, the Department may negotiate a reimbursement rate different than the rate then in effect for the facility. (5-8-09)

262. NURSING FACILITY: OUT-OF-STATE NURSING HOMES.
The Idaho Medicaid Program will reimburse for out-of-state nursing home placements when services are not available in Idaho to meet the participant's medical need, or in a temporary situation for a limited period of time required to safely transport the participant to an Idaho facility. Reimbursement for out-of-state nursing homes will be at the per diem rate set by the Medicaid Program in the state where the nursing home is located. Special rates will be allowed according to Section 270 of these rules. (3-19-07)

263. NURSING FACILITY: DISTRESSED FACILITY.

01. Determination. If the Department determines that a facility is located in an under-served area, or addresses an under-served need, the Department may negotiate a reimbursement rate different than the rate then in effect for that facility. (5-8-09)

02. Discretionary Factors. The fact that a facility may be located in an under-served area or meets an under-served need does not guarantee increased reimbursement. In exercising its discretion to apply a higher rate, the Department will consider the factors as described in Subsections 263.02.a. through 263.02.e. of this rule. (5-8-09)

a. Prudent Spending Patterns. The facility has exercised prudent spending and cost allocation practices, as evidenced by a thorough and comprehensive review of the facility's accounts by the Department. (5-8-09)

b. Reasonable Attempts to Remedy Problems. The facility must persuade the Department that it has conscientiously and diligently attempted to cover its costs of care, hire qualified staff and otherwise operate effectively and efficiently, but for causes beyond the facility's reasonable control, it has not been able to do so. (5-8-09)

c. Facility Already Receives Special Rates. When a facility already receives special rates for certain difficulty-of-care patients from the Department, the same costs of care that were used to determine special rates will not be applied toward a determination of distressed facility status, because the special rate meets that need. (5-8-09)

d. Direct and Indirect Costs of Care Apportioned to Patient Care. The Department reimburses the costs of patient care, and does not pay for indirect costs not associated with patient care. The determination of distressed status will focus on whether the facility's distress stems from patient care costs, or whether the distress arises from expenses unrelated to patient care costs. (5-8-09)

e. Existing Cost Limits.Under no circumstances may a facility's reimbursement exceed the lower of its actual costs or customary charge to private-pay patients, as required by federal law, subject to the exceptions in federal law. The Department's cost caps can be exceeded through the distressed facility process, but to an amount no greater than the federal upper payment limit. (5-8-09)

03. Annual Review. Distressed facility payments are assumed to be short-term in nature. Each distressed payment must be re-requested and re-justified for each subsequent fiscal year that the facility desires the distressed facility rate. (5-8-09)

04. Prospective Application. Distressed facility status will be applied only to facilities that are currently distressed or entering a period of distress. Distressed facility status will not be applied to retroactive rate years. (5-8-09)

05. Facility-by-Facility Basis. Each facility must independently establish distress on its own merits, whether or not other facilities with a common owner may also be experiencing distress. (5-8-09)

264. NURSING FACILITY: INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.
Certain costs may be excluded from the cost limit calculations, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rates as provided in this Section to assure equitable reimbursement: (3-19-07)

01. Changes of More Than Fifty Cents Per Patient Day in Costs. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. (3-19-07)

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. (3-19-07)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. (3-19-07)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (3-19-07)

02. Interim Rate Adjustments. For interim rate purposes, the provider may be granted an increase in its prospective rate to cover such cost increases. A cost statement covering a recent period may be required with justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (3-19-07)

03. Future Treatment of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases that have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. (3-19-07)

265. NURSING FACILITY: MDS REVIEWS.
The following Minimum Data Set (MDS) reviews will be conducted: (3-19-07)

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. (3-19-07)

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. (3-19-07)

266. NURSING FACILITY: BEHAVIORAL CARE UNIT (BCU) AND RATE STRUCTURE.
Effective October 1, 2012, the additional direct care costs associated with BCU residents will remain in direct care costs subject to the direct care cost limitation. Those qualifying BCU nursing facility providers may have a direct care

cost limitation higher than non-BCU nursing facility providers. BCU nursing facility providers will not receive an increased indirect care cost limitation. (4-4-13)

01. Determination. The BCU must have a qualifying program and have been providing care in the BCU to behavior residents as of July 1, 2011. Nursing facility providers that meet the BCU criteria will have BCU direct care costs included in direct care costs subject to the cost limit. The direct care cost limitation may be higher than a non-BCU nursing facility. (4-4-13)

02. BCU Routine Customary Charge. If the cost to operate a BCU is included in a nursing facility's rate calculation, the nursing facility must report its usual and customary charge for semi-private rooms in both the BCU and general nursing facility. A weighted average routine customary charge is computed to represent the composite of all Medicaid nursing facility residents in the nursing facility based on the type of rooms they occupy, including the BCU. (4-4-13)

03. Prospective Rate Setting. Beginning October 1, 2012, the direct care cost limit calculation for any special rate revenue offsets in the prior year related to one-to-one (1:1) staffing ratios, BCU, or increased staffing, will be reversed before calculating the cost limit. This revenue offset reversal excludes revenues related to special rate add-ons for ventilator-dependent or tracheostomy services. Rates will be calculated using the cost report ended in the calendar year prior to each July 1 rate setting period with the BCU's direct care costs included in direct care costs subject to the higher BCU cost limit. (4-4-13)

04. Annual Rates Beginning July 1, 2013. For annual rates beginning July 1, 2013, once a rate has been set as provided in Subsection 266.03 of this rule, the following process will be used to determine BCU eligibility. A nursing facility must apply for BCU eligibility on an annual basis. Eligibility is determined by: (4-4-13)

a. BCU days, regardless of payer source, are divided by the total occupied days in the nursing facility and that calculation equals or exceeds a minimum of twenty percent (20%). (4-4-13)

b. The BCU nursing facility provider must provide a list of all residents they believe were qualified for BCU status for the previous year; (4-4-13)

i. The Department will select a sample of Idaho Medicaid participants from the submitted list. The nursing facility provider must send the MDS for each selected sample participant, along with related census information, and other requested information to the Department. (4-4-13)

ii. The Department will review this information to determine that the participants meet the requirements of Subsection 266.06 of this rule and calculate the percentage of BCU days to the total occupied days in the facility to determine whether the facility meets the BCU eligibility requirement in Subsection 266.05.a. of this rule. (4-4-13)

05. Participant Characteristics. All participants in a BCU must meet the criteria for nursing facility level of care, and have the following characteristics as provided in the participants' MDS assessment: (4-4-13)

a. Medically based behavior disorder that causes a significantly diminished capacity for judgment, retention of information, or decision making skills, or medically based mental health disorder of diagnosis and has a high level resource use; and (4-4-13)

b. Must have a history or demonstrate need for additional resources to provide for disruptive behaviors requiring enhanced resource use from nursing facility staff, evidenced by one (1) or more of the following: (4-4-13)

i. Wandering behaviors; (4-4-13)

ii. Verbally abusive behaviors; (4-4-13)

iii. Physically abusive behaviors; (4-4-13)

iv. Socially inappropriate or disruptive behaviors, such as verbal or vocal symptoms like disruptive sounds, noises, screaming, physical symptoms like self-abusive acts, public sexual behavior or disrobing in public, smearing or throwing food or bodily wastes, hoarding, rummaging through belongings of other residents; (4-4-13)

v. Behaviors that resist care; or (4-4-13)

vi. Does not meet unit discharge criteria outlined in Subsection 266.13 of this rule. (4-4-13)

c. A behavior baseline profile must be established for each participant; (4-4-13)

d. A behavior intervention program must be in place for each participant, designed to reduce or control the inappropriate behaviors to enhance the participant's quality of life, functional and cognitive status or safety. (4-4-13)

06. BCU Annual Renewal. The facility must request continuation in the BCU program annually including the following: (4-4-13)

a. A description of the facility's program that includes the required components in Subsections 266.05 and 266.06 of this rule; and (4-4-13)

b. A profile of the types of behavior of participants served and any restrictions the facility has adopted. (4-4-13)

07. Administrative and Staffing Requirements. (4-4-13)

a. Staffing must be at a level necessary for the facility to be able to provide direct supervision of participants as needed. (4-4-13)

b. Psychiatrist or physician extender must be available to consult as needed for initial and on-going assessments and for twenty-four hours a day/seven days a week (24/7) emergency services. Consultants must make at least quarterly site visits and be available to participate in Behavior Management Team meetings as needed. (4-4-13)

c. Licensed Master Social Worker (LMSW), Licensed Professional Counselor (LPC), or Licensed Social Worker (LSW) with behavioral experience must be available to consult as needed, make periodic site visits and to participate in the assessment, behavioral intervention planning, behavioral intervention implementation and Behavior Management Team meetings as needed. (4-4-13)

08. Behavior Management Team Meetings. Weekly behavior management team meetings must be conducted that include psychiatrist, physician, facility social services staff, behavior program director, director of nursing services, dietary manager, recreational services or activity director, and selected primary care staff. Physicians, psychiatrists, social services consultants and other off-site specialists are included as needed, and may participate in person or by telephone. (3-20-20)

09. Staff Training. Behavioral training classes for staff that are tailored to the needs of the positions involved, and includes appropriate information on: (4-4-13)

a. Assessment and prevention; (4-4-13)

b. Medication and side effects; (4-4-13)

c. Effects of disease process on mood state; (4-4-13)

d. Safety techniques; (4-4-13)

e. Deflecting aggression or target behaviors; (4-4-13)

f. Comprehensive environmental intervention; (4-4-13)

g. Stress management; and (4-4-13)

h. Documentation and charting. (4-4-13)

10. **Yearly Training**. Yearly training for behavioral interventions and safety techniques is required for staff. (4-4-13)

11. **Care Planning, Behavioral Management, and Programming**. Individualized care plans, based on assessments of cognitive and functional abilities, along with behavior analysis to create a strategy for prevention and intervention that are documented for each participant and include the following: (4-4-13)

a. Thirty (30) day assessments of progress made by each participant, must be completed, documented, and reviewed by the facility's behavioral management team. (4-4-13)

b. Comprehensive behavior monitoring techniques that track and trend the intensity and daily occurrence of behaviors, successful interventions, and behavior modification techniques used must be documented for each participant. (4-4-13)

c. Attempts to involve family and responsible parties with the participant through visits, training, outings, or appropriate communications, must be documented. (4-4-13)

d. Recreational and activity programming must be targeted to specific needs of each individual participant and the behaviors each participant exhibits must be documented. (4-4-13)

e. Integration for appropriate social interactions must be used when appropriate for each individual participant. (4-4-13)

f. Community for transition must be used when appropriate for each individual participant. (4-4-13)

g. Attempts to meet discharge criteria must be documented for each individual participant when progress shows a decline in the need for special care programming. (4-4-13)

12. **Discharge Criteria**. The BCU must maintain and document discharge criteria as follows: (4-4-13)

a. Document improvement in ability to function that would enable transfer to less-restrictive environment. (4-4-13)

b. Document lack of benefit from specialized programs offered in BCU. (4-4-13)

c. Document consistent refusals by participant or responsible party to allow interventions that are determined to be helpful. (4-4-13)

d. Document acute danger to self or others that cannot be managed by staffing in the BCU. (4-4-13)

e. Document acute physical illness or complications requiring a higher level of medical care than available in the facility. (4-4-13)

13. **Termination of BCU Status**. If a provider opts to leave the BCU program, the Department must be notified so the direct care cap can be adjusted to that of a non-BCU provider, beginning with the next rate year. (4-4-13)

14. **Refusal of Admissions**. These rules do not preclude a nursing facility from refusing to admit a participant whose needs cannot be met by the nursing facility. (4-4-13)

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 thirty percent (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 thirty percent (30%) BCU occupancy requirement. (10-1-20)T

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 thirty percent (30%). (10-1-20)T

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)

269. NURSING FACILITY: NEW OWNER OF AN EXISTING NURSING FACILITY WITH A BEHAVIORAL CARE UNIT (BCU).

01. New Owner Elects to Continue BCU. An existing nursing facility that is considered a BCU will continue to be a BCU, if the new owner elects to continue to provide these services. The new owner will receive a rate calculated according to the current change of ownership rules in Section 261 of these rules. The prior owner's cost report will be used until the new owner has a qualifying cost report. They BCU will continue to qualify for the higher direct care cost limit the previous owner was allowed. (4-4-13)

02. New Owner Does Not Elect to Continue BCU. If the new owner does not elect to operate the BCU, the prior owner's cost report will be used. The direct care cost limit will be adjusted down to that of the non-BCU nursing facility. (4-4-13)

270. NURSING FACILITY: SPECIAL RATES.
A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions in these rules. (4-4-13)

01. Determination. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request will be based on an identified condition that will continue for a period greater than thirty (30) days. (3-4-11)

02. Effective Date. Upon approval, a special rate is effective on the date the application was received. (3-4-11)

03. Reporting. Costs equivalent to payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. (3-19-07)

04. Limitation. A special rate cannot exceed the provider's charges to other patients for similar services. (3-19-07)

05. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of this rule provide clarification of how special rates are paid under the prospective payment system. (4-4-13)

06. Determination of Payment for Qualifying Residents. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.c. of this rule. (4-4-13)

a. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit that included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period. (3-19-07)

b. Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not addressed in Section 225 of these rules as determined by the Department, are reimbursed in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 755, as an add-on amount. (4-4-13)

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. Nursing facilities providing care to residents who are ventilator-dependent or who receive tracheostomy care are eligible to submit requests for the fixed add-on amount, in addition to the facility's rate for residents receiving this type of care. Approved requests are effective the date the type of care is needed by the participant, or no earlier than sixty (60) days prior to the date the request is received by the Department. The rate includes the cost for equipment and supplies and for additional registered nurse and certified nursing assistant hours, as appropriate for each type of care. Costs for equipment and supplies will be adjusted annually for inflation, and registered nursing and certified nursing assistant costs will be adjusted according to the annual Weighted Average Hourly Rates (WAHR) survey results. (7-1-19)

i. Approved add-on rates for ventilator-dependent residents and residents receiving tracheostomy care are subject to annual reviews by the Department to ensure that the add-on rate remains necessary for the type of care needed by the resident. (7-1-19)

ii. The provider must inform the department if an approved add-on rate is no longer needed or if the resident requires a change from one type of care to another. (7-1-19)

d. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care in Out-of-State Nursing Facilities. For residents who are ventilator-dependent or receive tracheostomy care in an out-of-state facility, the add-on amount to the facility's rate is effective the date this type of care is needed by the participant or no earlier than sixty (60) days prior to the date the request is received by the Department. The add-on rate will include: (7-1-19)

i. Calculation of a staffing add-on for the cost, if any, for additional direct care staff required in meeting the exceptional needs of these residents. The hourly add-on rate is equal to the current WAHR CNA or current WAHR RN wage rate plus a benefits allowance based on annual cost report data, then weighted to remove the CNA minimum daily staffing time adjusted for the appropriate skill level of care staff; and (4-4-13)

ii. Calculation of an add-on for equipment and non-therapy supplies following the provisions in Subsection 270.06.b. of this rule. (4-4-13)

07. Treatment of the Special Rate Cost for Future Rate Setting Periods. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains special rate costs, an adjustment is made to "offset," or reduce costs by an amount equal to total incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. No related adjustment is made to the facility's CMIs. (4-4-13)

08. Special Rate for Providers that Change Ownership or Close. When a facility changes ownership or closes, a closing cost report is not required. Special rate payments made in the closing cost reporting period may be reviewed by the Department. (4-4-13)

271. (RESERVED)

272. NURSING FACILITY: LEGAL CONSULTANT FEES AND LITIGATION COSTS.
Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the

following: (3-19-07)

01. **In General**. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. (3-19-07)

02. **Administrative Appeals**. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. (3-19-07)

03. **Other**. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. (3-19-07)

273. NURSING FACILITY: PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (3-19-07)

01. **Use**. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (3-19-07)

02. **Provider Liability**. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (3-19-07)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (3-19-07)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or their agent in writing. (3-19-07)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (3-19-07)

03. **Fund Management**. Proper management of such funds would include the following as minimum: (3-19-07)

a. Savings accounts, maintained separately from facility funds. (3-19-07)

b. An accurate system of supporting receipts and disbursements to patients. (3-19-07)

c. Written authorization for all deductions. (3-19-07)

d. Signature verification. (3-19-07)

e. Deposit of all receipts of the same day as received. (3-19-07)

f. Minimal funds kept in the facility. (3-19-07)

g. As a minimum these funds must be kept locked at all times. (3-19-07)

h. Statement of policy regarding patient's funds and property. (3-19-07)

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (3-19-07)

j. System of periodic review and correction of policies and financial records of patient property and funds. (3-19-07)

274. NURSING FACILITY: IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this section. (3-19-07)

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 2002.

Licensed Bed Range	Upper limit
51 - 100	86,951
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

(3-19-07)

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by IHS Markit, its successor organization or, if unavailable, another nationally recognized forecasting firm. (3-20-20)

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 274.01 of these rules. Allowable compensation will be determined as follows: (3-19-07)

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility. (3-19-07)

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. (3-19-07)

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 274.01 of these rules. (3-19-07)

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. (3-19-07)

05. When an Owner Provides Services to More Than One Provider. When an owner provides

services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. (3-19-07)

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). (3-19-07)

275. NURSING FACILITY: PROPERTY RENTAL RATE REIMBURSEMENT.
Free standing nursing facilities other than hospital based nursing facilities will be paid a property rental rate. Property taxes and property insurance will be reimbursed as costs exempt from limitations. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit for free-standing nursing facilities, an interim rate for property reimbursement will be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code. (3-19-07)

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to Section 275.01 of these rules, and, beginning April 1, 1985, will be: (3-19-07)

R = “Property Base” x 40 - “Age” / 40 x “change in building costs” where: (3-19-07)

a. “R” = the property rental rate. (3-19-07)

b. “Property Base” = thirteen dollars and nineteen cents ($13.19) beginning October 1, 1996 for all freestanding nursing facilities. (3-19-07)

c. “Change in building costs” = 1.0 from October 1, 1996, through December 31, 1996. Beginning January 1, 1997, “change in building costs” will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as published by the Marshall Swift Valuation Service or the consumer price index for renter’s costs whichever is greater. For freestanding nursing facilities, the index available in September of the prior year will be used. (3-19-07)

d. “Age” of facility - The effective age of the facility in years will be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: (3-19-07)

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors’ records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula: (3-19-07)

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.

E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 275.01.d.ii.

If the result of this calculation, "r" is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). (3-19-07)

ii. Historical nursing home construction cost per square foot for purposes of evaluating facility age.

Age	Year	Cost	Age	Year	Cost	Age	Year	Cost
1	2004	82.41	**2**	2003	80.80	**3**	2002	79.06
4	2001	78.43	**5**	2000	74.34	**6**	1999	71.55
7	1998	71.34	**8**	1997	68.20	**9**	1996	67.59
10	1995	66.19	**11**	1994	64.14	**12**	1993	60.56
13	1992	59.03	**14**	1991	56.13	**15**	1990	54.61
16	1989	53.17	**17**	1988	52.03	**18**	1987	51.66
19	1986	51.56	**20**	1985	50.55			

(3-19-07)

iii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 275.01.d.i. of these rules. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for "C" will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. (3-19-07)

iv. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. (3-19-07)

v. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 275.01.d.iii. and 275.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider. (3-19-07)

vi. Effective July 1, 1991, for freestanding nursing facilities, "age of facility" will be a revised age that is the lesser of the age established under other provisions of this Section or the age that most closely yields the rate allowable to existing facilities as of June 30, 1991, under Subsection 275.01 of these rules. This revised age will not increase over time. (3-19-07)

02. Grandfathered Rate. A "grandfathered property rental rate" for existing free-standing nursing facilities will be determined by dividing the audited allowable annualized property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient days in the period July 1, 1984, through June 30, 1985. (3-19-07)

a. Prior to audit settlement, the interim rate for property costs allowable as of January 1, 1985, will be used to approximate the grandfathered rate. (3-19-07)

b. The grandfathered property rental rate will be adjusted to compensate the facility for the property costs of major repairs, replacement, expansion, remodeling or renovation initiated prior to April 1, 1985, and completed during calendar year 1985. (3-19-07)

c. Beginning July 1, 1989, facilities receiving grandfathered rates may have those rates adjusted for modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1986, if the cost of these modifications would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i.of these rules. The grandfathered rate will be revised after completion of modifications and will be the greater of: (3-19-07)

i. The grandfathered rate previously allowed; or (3-19-07)

ii. The actual per diem property costs of amortization, depreciation and interest not applicable to the modifications for the audit period in which the modifications were completed plus the per diem rate of the first year amortization of the cost of these modifications when amortized over American Hospital Association guideline useful life or lives. However, no change in the grandfathered rate will be allowed to change that rate by more than three-fourths (3/4) of the difference between the previous grandfathered rate and the property rental rate that would be paid for a new building at the time of the proposed rate revision. (3-19-07)

d. The facility will be reimbursed a rate that is the higher of the grandfathered property rental rate as determined according to provisions of Subsection 275.02 of these rules or the property rental rate determined according to Subsections 275.01, 275.03, or 275.05 of these rules. (3-19-07)

03. Leased Freestanding Nursing Facilities. Freestanding nursing facilities with leases will not be reimbursed in the same manner specified in Subsections 275.01 and 275.02 of these rules. Provisions in this section do not apply to reimbursement of home office costs. Home office costs will be paid based on reasonable cost principles. (3-19-07)

a. Facilities with leases entered into on or after March 30, 1981, are to be reimbursed in the same way as owned facilities with ownership costs being recognized instead of lease costs. (3-19-07)

b. Facilities with leases entered into prior to March 30, 1981, will not be subject to reimbursement according to the provisions of Subsections 275.01 or 275.02 of these rules. Their property rental rate per day of care will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983, through July 1, 1984. (3-19-07)

i. Effective July 1, 1989, the property rental rates of leased nursing facilities with leases entered into prior to March 30, 1981, may be adjusted to compensate for increased property costs resulting from facility modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1985, if the cost would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i. of these rules. The rate will be revised after the completion of such modifications and will be the greater of the property rental rate previously allowed under Subsection 275.03, or the actual per diem property costs for the amortization, depreciation, and interest not applicable to the modifications for the reporting period in which the

modifications were completed, plus the per diem of the first year amortization of the modification expenses using the American Hospital Association guideline useful life of lives. However, no such rate change will increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the previous rate and the property rental rate that would be allowed for a new building at the time of the proposed rate revision. (3-19-07)

ii. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement will be at a rate per day of care that reflects the increase in the lease rate. (3-19-07)

iii. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement will be at a rate per day of care that reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters' costs. After April 1, 1985, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by an option to purchase the facility, the property rental rate will become the amount "R" determined by the formula in Subsection 275.01 of these rules as of the date on which the lease is or could be terminated. (3-19-07)

04. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Subsection 275.01 of these rules, except in the event of a forced sale or except in the event of a first sale of a facility receiving a "grandfathered rate" after June 30, 1991, whereupon the property rental rate of the new owner will be computed as if no sale had taken place. (3-19-07)

05. Forced Sale of a Facility. In the event of a forced sale of a facility, or asset of a facility, where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon their incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, not modified by Section 275 of these rules**,** whichever is higher, but not exceeding the rate that would be due the seller. (3-19-07)

276. -- 277. (RESERVED)

278. NURSING FACILITY: OCCUPANCY ADJUSTMENT FACTOR.
In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: (3-19-07)

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section 013 of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. (3-19-07)

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (3-19-07)

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. (3-19-07)

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (3-19-07)

05. **New Facility**. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (3-19-07)

279. NURSING FACILITY: RECAPTURE OF DEPRECIATION.
Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (3-19-07)

01. **Amount Recaptured**. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. (3-19-07)

02. **Time Frame**. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (3-19-07)

280. NURSING FACILITY: REPORTING SYSTEM.
The objective of the reporting requirements is to provide a uniform system of periodic reports that will allow: (3-19-07)

01. **Basis for Reimbursement**. A basis of provider reimbursement approximating actual costs. (3-19-07)

02. **Disclosure**. Adequate financial disclosure. (3-19-07)

03. **Statistical Resources**. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. (3-19-07)

04. **Criteria**. Criteria for evaluating policies and procedures. (3-19-07)

281. NURSING FACILITY: REPORTING SYSTEM PRINCIPLE AND APPLICATION.
The provider will be required to file mandatory annual cost reports. (3-19-07)

01. **Cost Report Requirements**. The fiscal year end cost report filing must include: (3-19-07)

a. Annual income statement (two (2) copies); (3-19-07)

b. Balance sheet; (3-19-07)

c. Statement of ownership; (3-19-07)

d. Schedule of patient days; (3-19-07)

e. Schedule of private patient charges; (3-19-07)

f. Statement of additional charges to residents over and above usual monthly rate; and (3-19-07)

g. Other schedules, statements, and documents as requested. (3-19-07)

02. **Special Reports**. Special reports may be required. Specific instructions will be issued, based upon the circumstance. (3-19-07)

03. **Criteria of Reports**. All reports must meet the following criteria: (3-19-07)

a. State-approved formats used. (3-19-07)

b. Presented on accrual basis. (3-19-07)

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (3-19-07)

d. Appropriate detail provided on supporting schedules or as requested. (3-19-07)

04. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. (3-19-07)

05. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (3-19-07)

06. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements must be met: (3-19-07)

a. Outgoing management or administration must file an adjusted-period cost report if they are being reimbursed on a retrospective basis at the time of the charge. This report must meet the criteria for annual cost reports, except that it is not filed later than sixty (60) days after the change in management or ownership for the purpose of computing a final program settlement. (3-19-07)

b. The Department may require an appraisal at the time of a change in ownership. (3-19-07)

c. Providers who are receiving a new provider rate or being reimbursed on a prospective basis, when the change of management or ownership occurs, will not be required to file a closing cost report. (3-19-07)

282. NURSING FACILITY: REPORTING PERIOD.
For purposes of nursing facility rate setting, cost report periods of less than six (6) months will not be used. If a provider changes their fiscal year-end or experiences a change in ownership, the last cost report filed by that facility that is greater than six (6) months will be used until a cost report exceeding six (6) months is received from the new owner, or is based on the new fiscal year. (3-19-07)

283. NURSING FACILITY: FILING DATES.

01. Deadlines. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. (3-19-07)

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (3-19-07)

284. NURSING FACILITY: FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (3-19-07)

285. NURSING FACILITY: ACCOUNTING SYSTEM.

Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (3-19-07)

286. NURSING FACILITY: AUDITS.
All financial reports are subject to audit by Departmental representatives. (3-19-07)

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (3-19-07)

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. (3-19-07)

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the required care on the a basis of economy and efficiency. (3-19-07)

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (3-19-07)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding their fiduciary responsibilities for patients, funds and property. (3-19-07)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (3-19-07)

07. Compliance. To provide recommendations that will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program participants. (3-19-07)

08. Final Settlement. To effect final settlement when required by **Sections** 250 through 296 of these rules. (3-19-07)

287. NURSING FACILITY: AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. (3-19-07)

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (3-19-07)

03. Additional Audits. In addition, audits may be required where: (3-19-07)

a. A significant change of ownership occurs. (3-19-07)

b. A change of management occurs. (3-19-07)

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (3-19-07)

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (3-19-07)

288. NURSING FACILITY: AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the

provider to comply with program requirements. (3-19-07)

02. **Requirements**. Providers Reimbursement Manual (PRM), Section 2404.3, states: "Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. (3-19-07)

03. **Examination of Records**. Examination of records and documents may include: (3-19-07)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (3-19-07)

b. Minutes and memos of the governing body including committees and its agents. (3-19-07)

c. All contracts. (3-19-07)

d. Tax returns and records, including workpapers and other supporting documentation. (3-19-07)

e. All insurance contracts and policies including riders and attachments. (3-19-07)

f. Leases. (3-19-07)

g. Fixed asset records (see audit section - Capitalization of Assets). (3-19-07)

h. Schedules of patient charges. (3-19-07)

i. Notes, bonds and other evidences of liability. (3-19-07)

j. Capital expenditure records. (3-19-07)

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (3-19-07)

l. Evidence of litigations the facility and its owners are involved in. (3-19-07)

m. Documents of ownership including attachments that describe the property. (3-19-07)

n. All invoices, statements and claims. (3-19-07)

o. Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, Subparagraph 2404.4(Q). (3-19-07)

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (3-19-07)

q. All patient records, including trust funds and property. (3-19-07)

r. Time studies and other cost determining information. (3-19-07)

s. All other sources of information needed to form an audit opinion. (3-19-07)

04. **Adequate Documentation**. (3-19-07)

a. Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation that pertains to the

determination of reasonable cost, capable of being audited under PRM, Section 2304. (3-19-07)

b. Adequate expenses documentation including an invoice, or a statement with invoices attached that support the statement. All invoices should meet the following standards: (3-19-07)

i. Date of service or sale; (3-19-07)

ii. Terms and discounts; (3-19-07)

iii. Quantity; (3-19-07)

iv. Price; (3-19-07)

v. Vendor name and address; (3-19-07)

vi. Delivery address if applicable; (3-19-07)

vii. Contract or agreement references; and (3-19-07)

viii. Description, including quantity, sizes, specifications brand name, services performed. (3-19-07)

c. Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (3-19-07)

d. Completed depreciation records must meet the following criteria for each asset: (3-19-07)

i. Description of the asset including serial number, make, model, accessories, and location. (3-19-07)

ii. Cost basis should be supported by invoices for purchase, installation, etc. (3-19-07)

iii. Estimated useful life. (3-19-07)

iv. Depreciation method such as straight line, double declining balance, etc. (3-19-07)

v. Salvage value. (3-19-07)

vi. Method of recording depreciation on a basis consistent with accounting policies. (3-19-07)

vii. Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (3-19-07)

viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. (3-19-07)

e. Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (3-19-07)

f. The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition. Guidelines Lives, which is incorporated by reference under Section 004 of these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. (3-19-07)

g. Lease purchase agreements may generally be recognized by the following characteristics: (3-19-07)

i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (3-19-07)

ii. Intent to create security interest; (3-19-07)

iii. Lessee may acquire title through exercise of purchase option that requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (3-19-07)

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (3-19-07)

v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (3-19-07)

h. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (3-19-07)

i. Complete personnel records normally contain the following: (3-19-07)

i. Application for employment. (3-19-07)

ii. W-4 Form. (3-19-07)

iii. Authorization for other deductions such as insurance, credit union, etc. (3-19-07)

iv. Routine evaluations. (3-19-07)

v. Pay raise authorization. (3-19-07)

vi. Statement of understanding of policies, procedures, etc. (3-19-07)

vii. Fidelity bond application (where applicable). (3-19-07)

05. Internal Control. (3-19-07)

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (3-19-07)

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (3-19-07)

ii. Promoting accuracy and reliability in financial records. (3-19-07)

iii. Encouraging and measuring compliance with company policy and legal requirements. (3-19-07)

iv. Determining the degree of efficiency related to various aspects of operations. (3-19-07)

b. An adequate system of internal control over cash disbursements would normally include: (3-19-07)

i. Payment on invoices only, or statements supported by invoices. (3-19-07)

ii. Authorization for purchase such as a purchase order. (3-19-07)

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (3-19-07)

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (3-19-07)

v. Check of invoice accuracy. (3-19-07)

vi. Approval policy for invoices. (3-19-07)

vii. Method of invoice cancellation to prevent duplicating payment. (3-19-07)

viii. Adequate separation of duties between ordering, recording, and paying. (3-19-07)

ix. System separation of duties between ordering, recording, and paying. (3-19-07)

x. Signature policy. (3-19-07)

xi. Pre-numbered checks. (3-19-07)

xii. Statement of policy regarding cash or check expenditures. (3-19-07)

xiii. Adequate internal control over the recording of transactions in the books of record. (3-19-07)

xiv. An imprest system for petty cash. (3-19-07)

06. Accounting Practices. Sound accounting practices normally include the following: (3-19-07)

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (3-19-07)

b. Chart of accounts. (3-19-07)

c. A budget or operating plan. (3-19-07)

289. -- 290. (RESERVED)

291. NURSING FACILITY: COSTS FOR THE COMPLETION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPS) AND FOR COMPLYING WITH CERTAIN OTHER REQUIREMENTS.
Provisions of federal law require the state to give special treatment to costs related to the completion of training and competency evaluation of nurse aides and to increase rates related to other new requirements. Treatment will be as follows: (3-19-07)

01. Cost Reimbursement. Effective for cost reports filed and for payments made after April 1, 1990, NATCEP costs will be outside the content of nursing facility care and will be reported separately as exempt costs. (3-19-07)

02. Costs Subject to Audit. Such NATCEP costs are subject to audit, and must be reported by all nursing facilities, including those that are hospital-based, and are not included in the percentile cap. (3-19-07)

292. NURSING FACILITY: PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE.
Payments may be made for reserving beds in long-term care facilities for participants during their temporary absence if the facility charges private paying patients for reserve bed days, subject to the following limitations: (3-19-07)

01. Facility Occupancy Limits. Payment for periods of temporary absence from long term care facilities will not be made when the number of unoccupied beds in the facility on the day preceding the period of temporary absence in question is equal to or greater than: (3-19-07)

a. If licensed beds are less than one hundred (<100) and they have five (5) or more beds unoccupied, leave of absence payments are not allowed. (3-19-07)

b. If licensed beds are greater than or equal to one hundred (>100), they must have a minimum occupancy rate of ninety-five percent (95%) for leave of absence payments to be allowed. (3-19-07)

02. Time Limits. Payments for periods of temporary absence from long term care facilities will be made for therapeutic home visits for nursing facility residents of up to three (3) days per visit and not to exceed a total of fifteen (15) days per calendar year so long as the days are part of a treatment plan ordered by the attending physician. (3-19-07)

03. Limits on Amount of Payments. Payment for reserve bed days will be the lesser of the following: (3-19-07)

i. Seventy-five percent (75%) of the audited allowable costs of the facility; or (3-19-07)

ii. The rate charged to private paying patients for reserve bed days. (3-19-07)

04. Payment Procedures. Each long term care facility must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim on behalf of a medical assistance participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. (3-19-07)

293. -- 299. (RESERVED)

300. PERSONAL CARE SERVICES (PCS).

01. Description of Personal Care Services (PCS). Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide personal care services (PCS) to eligible participants in their own homes or personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. (3-13-20)T

02. Temporary Changes to PCS Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PCS services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. Changes already in affect at the time of this rulemaking supersede existing rule and include: (3-13-20)T

a. Criminal History Background Checks. (Amends Subsections: 009.03.b., 009.03.k., 009.03.l., and 305.06) Newly hired direct care staff may begin rendering services prior to a completed criminal history background check as long as all of the conditions in Medicaid Information Release MA20-15 are met. (3-13-20)T

b. Direct Care Staff Training Requirements. (Amends Subsection: 305.02) Newly hired direct care staff may begin rendering services prior to the requirements associated with the provider's agency type or service array according to guidance in the Medicaid Information Release MA20-15. (3-13-20)T

c. General Compliance and Oversight Activities. (Amends Sections: 304 and 308) Service providers may, at their discretion, implement the following changes to routine compliance and oversight activities according to guidance in the Medicaid Information Release MA20-15. Allowable changes include: (3-13-20)T

i. Suspending supervisory on-sight visits. (3-13-20)T

ii. Suspending face-to-face service plan development. (3-13-20)T

iii. Utilizing telehealth to provide services. Medicaid Information Release MA20-07 provides further guidance for providers able to use telehealth. (3-13-20)T

iv. Allowing alternative formats for signature requirements (such as electronic signatures). (3-13-20)T

v. Suspending the Department's on-site agency reviews. (3-13-20)T

d. Postponement of Annual Redeterminations. (Amends Subsection: 302.04) The Bureau of Long Term Care (BLTC) may postpone annual redeterminations at the discretion of the Department in order to prioritize workloads related to assessments for new waiver applicants and participants with significant changes. (3-13-20)T

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. (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 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)

302. PERSONAL CARE SERVICES: ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." (3-19-07)

02. Other Eligibility Requirements. Bureau of Long Term Care (BLTC) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-20-20)

a. The BLTC finds that the participant is capable of being maintained safely and effectively in their own home or personal residence using PCS. (3-20-20)

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed, or a child for whom a children's PCS assessment has been completed; (3-29-10)

c. The BLTC reviews the documentation for medical necessity; and (3-20-20)

d. The participant has a plan of care that meets the person-centered planning requirements described in Sections 316 and 317 of these rules. (7-1-16)

03. State Plan Option. A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds they require PCS due to a medical condition that impairs their physical, mental function, or independence. (3-19-07)

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. Throughout the duration of the COVID-19 state of emergency, the Bureau of Long Term Care (BLTC) may postpone annual redeterminations at the discretion of the Department in order to prioritize workloads related to assessments for new waiver applicants and participants with significant changes. (3-13-20)T

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Eligibility for Aid to the Aged,

Blind, and Disabled (AABD)." BLTC will make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QIDP, or the physician. (3-20-20)

b. The medical redetermination assesses the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

303. PERSONAL CARE SERVICES: COVERAGE AND LIMITATIONS.

01. Medical Care and Services. PCS services include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services: (3-19-07)

a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; (3-19-07)

b. Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; (3-19-07)

c. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (3-29-10)

d. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities; (3-29-10)

e. Assisting the participant with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; (3-29-10)

f. Non-nasogastric gastrostomy tube feedings if authorized by BLTC prior to implementation and if the following requirements are met: (3-20-20)

i. The task is not complex and can be safely performed in the given participant care situation; (3-19-07)

ii. A Licensed Registered Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs; (3-19-07)

iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly; (3-19-07)

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; (3-19-07)

v. The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN and must be readily available for review, preferably with the participant's record; and (3-19-07)

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if

authorized by the supervising RN. (3-19-07)

02. Non-Medical Care and Services. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 303.01.a. through 303.01.f. of this rule, the provider may also perform the following services, if no natural supports are available: (3-29-10)

a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded. (3-19-07)

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. (3-19-07)

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. (3-19-07)

03. Place of Service Delivery. PCS may be provided in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home or a Residential Assisted Living Facility, or a PCS Family Alternate Care Home. The following living situations are specifically excluded as a personal residence: (3-20-20)

a. Certified nursing facilities or hospitals. (3-19-07)

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

c. A home that receives payment for specialized foster care, professional foster care or group foster care, as described in IDAPA 16.06.01, "Child and Family Services." (3-19-07)

04. Type of Service Limitations. The provider is excluded from delivering the following services: (3-19-07)

a. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; (3-19-07)

b. Insertion or sterile irrigation of catheters; (3-19-07)

c. Injecting fluids into the veins, muscles or skin; and (3-19-07)

d. Administering medication. (3-19-07)

05. Participant Service Limitations. (3-19-07)

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen (16) hours per week per participant. (3-19-07)

b. Children who meet the necessity criteria for EPSDT services under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Section 882, may receive up to twenty-four (24) hours per day of PCS per child through the month of their twenty-first birthday. (3-19-07)

06. Provider Coverage Limitations. (3-19-07)

a. The provider must not bill for more time than was actually spent in service delivery. (3-19-07)

b. No provider home, regardless of the number of providers in the home, may serve more than two (2) children who are authorized for eight (8) or more hours of PCS per day. (3-19-07)

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 all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. (3-20-20)

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

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

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

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

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

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The 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 in the participant's 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 System. Agencies may employ a software system that allows personal assistants to register their start and stop times and a list of services by placing a telephone call to the agency system from the participant's home. This system will not take the place of documentation requirements of Subsection 304.04 of these rules. (3-19-07)

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 or Certified Family Home. (7-1-16)

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

b. Participant in a Certified Family Home. The additional PCS record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "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)

07. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

305. PERSONAL CARE SERVICES: PROVIDER QUALIFICATIONS.

01. Provider Qualifications for Personal Assistants. All personal assistants must have at least one (1) of the following qualifications: (3-19-07)

a. Licensed Registered Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse; (3-19-07)

b. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (3-19-07)

c. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. The BLTC may require a certified nursing assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA. (3-20-20)

02. Provider Training Requirements. In the case where care is provided in the participant's own home, and the participant has a developmental disability that is not physical only and requires more than physical assistance, all those who provide care must have: (3-19-07)

a. Completed one (1) of the Department-approved developmental disabilities training courses; or (3-19-07)

b. Experience providing direct services to people with developmental disabilities. (3-19-07)

c. BLTC determines whether developmental disability training is required. Providers who are qualified as QIDPs are exempted from the Department-approved developmental disabilities training course. (3-20-20)

d. In order to serve a participant with a developmental disability, a region may temporarily approve a PCS provider who meets all qualifications except for the required training course or experience, if all the following conditions are met: (3-19-07)

i. The BLTC verifies that there are no other qualified providers available; (3-20-20)

ii. The provider is enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary provider status; and (3-19-07)

iii. The supervising QIDP makes monthly visits until the provider graduates from the training program. (3-19-07)

03. Provider Exclusion. If PCS is paid for by Medicaid, a PCS service provider cannot be the spouse of any participant or be the parent of a participant if the participant is a minor child. (3-19-07)

04. Care Delivered in Provider's Home for a Child. When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care. The provider must be licensed for care of individuals under age eighteen (18), as defined in Section 39-1213, Idaho Code. Noncompliance with these standards is cause for termination of the provider's provider agreement. (3-19-07)

05. Care Delivered in Provider's Home for an Adult. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a Certified Family Home under IDAPA 16.03.19, "Certified Family Homes." (3-19-07)

06. Criminal History Check. All PCS providers, including service coordinators, RN supervisors, QIDP supervisors and personal assistants, must participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check must be conducted in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (3-19-07)

07. Health Screen. Each Personal Assistance Agency employee who serves as a personal assistant must complete a health questionnaire. Personal Assistance Agencies must retain the health questionnaire in their personnel files. If the personal assistant indicates on the questionnaire that they have a medical problem, they are required to submit a statement from a physician or authorized provider that their medical condition does not prevent them from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health questionnaire may be cause for termination of employment for the personal assistant and would disqualify the employee to provide services to Medicaid participants. (3-19-07)

306. PERSONAL ASSISTANCE AGENCY (PAA): QUALIFICATIONS AND DUTIES.

01. Provider Agreement Required. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services in accordance with Section 329 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. (5-8-09)

02. Responsibilities of a Personal Assistance Agency. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: (3-19-07)

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; (3-19-07)

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; (3-19-07)

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; (3-19-07)

d. Provision of a licensed registered nurse (RN) or, where applicable, a QIDP supervisor to develop and complete plans of care and provide ongoing supervision of a participant's care; (3-19-07)

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; (3-19-07)

f. Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; (3-19-07)

g. Billing Medicaid for services approved and authorized by the BLTC; (3-20-20)

h. Collecting any participant contribution due; (5-8-09)

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

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 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 or Certified Family Homes. Adult participants living in Residential Assisted Living Facilities (RALF) or Certified Family Homes will receive personal care services at a rate based on their care level. Each level will convert to a specific number of hours of personal care services. (3-19-07)

a. Reimbursement Level I -- One point twenty-five (1.25) hours of personal care services 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 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 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 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 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 Reimbursement Level. The supervisory RN and QMRP will be 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 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)

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

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

05. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

309. (RESERVED)

SUB AREA: HOME AND COMMUNITY-BASED SERVICES
(Sections 310-317)

310. HOME AND COMMUNITY-BASED SERVICES.
Home and Community-Based Services (HCBS) are those services and supports that assist eligible participants to remain in their home and community. The federal authorities under 42 CFR 441.301, 42 CFR 441.710, and 42 CFR 441.725 require the state to deliver HCBS in accordance with the rules described in Sections 310 through 319 of these rules. HCBS include the following: (4-11-19)

01. Children's Developmental Disability Services. Children's developmental disability services as defined in Sections 663 and 683 of these rules. (7-1-16)

02. Adult Developmental Disability Services. Adult developmental disability services as defined in Sections 645 through 659, 703, and 705 of these rules. (7-1-16)

03. Consumer-Directed Services. Consumer-directed services as defined in IDAPA 16.03.13, "Consumer-Directed Services." (7-1-16)

04. Aged and Disabled Waiver Services. Aged and disabled waiver services as defined in Section 326 of these rules. (7-1-16)

05. Personal Care Services. Personal care services as defined in Section 303 of these rules. (7-1-16)

06. Services for Children with Serious Emotional Disturbance (SED). SED services, as defined in Section 368 of these rules, for children who are enrolled in the Medicaid SED program in support of Youth Empowerment Services (YES). (4-11-19)

311. HCBS REQUIREMENTS AND DECISION-MAKING AUTHORITY.
HCBS requirements, contained in Sections 312 through Sections 317 of these rules, do not supersede decision-making authority legally assigned to another individual or entity on the participant's behalf. This includes: (7-1-16)

01. Payee. A representative payee appointed by the Social Security Administration; (7-1-16)

02. Restrictions (Probation or Parole). Court-imposed restrictions related to probation or parole; (7-1-16)

03. Restrictions (When Committed). Court-imposed restrictions when committed to the Director of Health and Welfare; and (7-1-16)

04. Legal Guardians Who Retain Full Decision-making Authority. It is presumed that the parent or parents of participants birth through seventeen (17) years of age have full decision-making authority unless the minor child has another legally assigned decision-making authority. (7-1-16)

312. HOME AND COMMUNITY-BASED SETTINGS.
Home and community-based settings include all locations where participants who receive HCBS live or receive their services. (7-1-16)

01. Home and Community-Based Settings Not Included. Home and community-based settings do not include the following: (7-1-16)

a. A nursing facility; (7-1-16)

b. An institution for mental diseases; (7-1-16)

c. An intermediate care facility for persons with intellectual disabilities (ICF/ID); (7-1-16)

d. A hospital; or (7-1-16)

e. Any other location that has the qualities of an institutional setting. These institutional qualities include: (7-1-16)

i. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; or (7-1-16)

ii. A building on the grounds of, or immediately adjacent to, a state or federally operated inpatient treatment facility; or (7-1-16)

iii. Any setting that has the effect of isolating participants receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. (7-1-16)

313. REQUIRED HOME AND COMMUNITY-BASED QUALITIES.
Home and community-based settings must support eligible participants to have the same opportunities for integration, independence, choice, and rights as individuals who do not require supports or services to remain in their home or community. If a setting requirement described in this rule presents a health or safety risk to the participant or those around the participant, goals must be identified with strategies to mitigate the risk. These goals and strategies must be documented in the person-centered plan. Providers must develop and implement policies and procedures to address the following HCBS setting requirements. (7-1-16)

01. Required Home and Community-Based Qualities. Home and community-based settings are required to have the following qualities: (7-1-16)

a. Integration and Access. The setting is integrated in and supports full access to the greater community for participants receiving HCBS. Typical, age-appropriate activities include opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals who do not require supports or services to remain in their home or community. (7-1-16)

b. Selection of Setting. Home and community-based settings are selected by the participant or the participant's decision-making authority from among disability-specific and non-disability-specific settings, and are based on the participant's needs and preferences including consideration of the participant's safety and the safety of those around the participant. (7-1-16)

c. Participant Rights. The setting ensures a participant's rights of privacy, dignity, and respect, and freedom from coercion and unauthorized restraint are honored. (7-1-16)

d. Autonomy and Independence. The setting optimizes, but does not regiment, an individual's initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact. (7-1-16)

e. Choice. The setting promotes opportunities for participant choice regarding the services and supports provided in the setting. (7-1-16)

02. Services Delivered in the Participant's Own Home. It is presumed that services delivered in the participant's own home, that is not a provider-owned or controlled residence, meet the HCBS setting requirements described in this rule. Providers may not impose restrictions on HCBS setting qualities in a participant's own home without goals and strategies to mitigate risk described in this rule that have been agreed to through the person-centered planning process. (7-1-16)

314. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
In addition to the setting requirements described in Section 313 of these rules, provider-owned or controlled settings, including Residential Assisted Living Facilities and Certified Family Homes that provide services to HCBS participants, must also meet the following conditions: (7-1-16)

01. Written Agreement. A lease, residency agreement, admission agreement, or other form of written

agreement will be in place for each HCBS participant at the time of occupancy. The lease or residency agreement must provide protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. (7-1-16)

02. **Privacy**. Participants have the right to privacy within their residence. Each participant must have privacy in their sleeping or living unit to include the following: (7-1-16)

a. The right to entrance doors that are lockable by the individual, with only appropriate staff having keys to doors. (7-1-16)

b. Participants sharing units have a choice of roommates in that setting. (7-1-16)

03. **Décor**. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. (7-1-16)

04. **Schedules and Activities**. Participants have the freedom and support to control their own schedules and activities. (7-1-16)

05. **Access To Food**. Participants have access to food at any time. (7-1-16)

06. **Visitors**. Participants are able to have visitors of their choosing at any time in accordance with the applicable requirements under IDAPA 16.03.19, "Certified Family Homes," and IDAPA 16.03.22, "Residential Assisted Living Facilities." Except, through the duration of the declared COVID-19 public health emergency, CFH providers may restrict visitation to minimize the spread of the COVID-19 infection. (3-13-20)T

07. **Accessibility**. The setting is physically accessible to the participant. (7-1-16)

315. EXCEPTIONS TO RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.

Exceptions to residential setting requirements outlined in Section 314 of these rules must be made based on the needs of the participant that are identified through person-centered planning. Service plans with exceptions to residential setting requirements must be submitted to the Department or its designee for review and approval. When an exception is made, the following information must be documented in the person-centered service plan: (7-1-16)

01. **Assessed Needs**. Specific and individualized assessed needs that are related to the exception. (7-1-16)

02. **Interventions and Supports**. Positive interventions and supports used prior to any exceptions to the person-centered service plan. (7-1-16)

03. **Prior Methods**. List less intrusive methods previously implemented that were unsuccessful in addressing the needs of the participant. (7-1-16)

04. **Description of Intervention**. A clear description of the intervention for the exception that is directly proportionate to the specific assessed needs. (7-1-16)

05. **Data Collection**. Regular collection and review of data to measure the ongoing effectiveness of the exception. (7-1-16)

06. **Time Limits**. Established time limits for periodic reviews to determine if the exception is still necessary, if a transition plan can be developed, or if the exception can be terminated. (7-1-16)

07. **Informed Consent**. Informed consent of the participant or legal guardian for the exception. (7-1-16)

08. **Assurance of No Harm**. An assurance that interventions and supports will cause no harm to the participant. (7-1-16)

316. HOME AND COMMUNITY-BASED PERSON-CENTERED PLANNING REQUIREMENTS.
All participants or their decision-making authority must direct the development of their service plan through a person-centered planning process. Information and support must be given to the HCBS participant to maximize their ability to make informed choices and decisions. Individuals invited to participate in the person-centered planning process should be identified by the participant or the participant's decision-making authority. Legal guardians who do not have full decision-making authority as described in Section 311 of these rules will have a participatory role as needed and defined by the participant. The person-centered planning process must: (7-1-16)

01. Timely and Convenient. Be conducted timely and occur at convenient times and locations to the participant and the participant's decision-making authority in accordance with program requirements. (7-1-16)

02. Cultural Considerations. Reflect cultural considerations of the participant. (7-1-16)

03. In Plain Language and Accessible. Be conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and persons who are limited English proficient as defined in 42 CFR 435.905(b). (7-1-16)

04. Conflict Resolution. Utilize strategies for solving conflict or disagreement within the process, and follow clear conflict-of-interest guidelines for all planning participants. (7-1-16)

317. HOME AND COMMUNITY-BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS.
All person-centered service plans must reflect the following components: (7-1-16)

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. (7-1-16)

02. Service Delivery Preferences. Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports. (7-1-16)

03. Setting Selection. HCBS settings selected by the participant or the participant's decision-making authority are chosen from among a variety of setting options, as required in Section 313 of these rules. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority. (7-1-16)

04. Participant Strengths and Preferences. (7-1-16)

05. Individually Identified Goals and Desired Outcomes. (7-1-16)

06. Paid and Unpaid Services and Supports. Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. (7-1-16)

07. Risk Factors. Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed. (7-1-16)

08. Understandable Language. Be understandable to the participant receiving services and supports, and the individuals important in supporting them. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). (7-1-16)

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. (7-1-16)

10. Plan Signatures. Be finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of

service and consistent with home and community-based requirements. (7-1-16)

a. Children's DD service providers responsible for implementation of the plan include the providers of those services defined in Sections 663 and 683 of these rules. (7-1-16)

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. (7-1-16)

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency as identified in IDAPA 16.03.13, "Consumer-Directed Services." (7-1-16)

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services defined in Sections 303 and 326 of these rules. Alternate format signatures may be used; refer to Medicaid Information Release MA20-15 for guidance. (3-13-20)T

11. Plan Distribution. Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. At a minimum, the following providers will receive a copy of the plan: (7-1-16)

a. Children's DD providers of services defined in Sections 663 and 683 of these rules as identified on the plan of service developed by the family-centered planning team. (7-1-16)

b. Adult DD service providers required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. (7-1-16)

c. Consumer-Directed service providers as defined in IDAPA 16.03.13, "Consumer-Directed Services," Section 110. Additionally, the participant, or the participant's decision-making authority will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors. (7-1-16)

d. Personal Care and Aged and Disabled Waiver service providers furnishing those services defined in Sections 303 and 326 of these rules. (7-1-16)

12. Residential Requirements. For participants living in residential provider owned or controlled settings as described in Section 314 of these rules, the following additional requirements apply: (7-1-16)

a. Options described in Subsection 317.03 of this rule must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. (7-1-16)

b. Any exception to residential provider owned or controlled setting qualities as described in Section 314 of these rules must be documented in the person-centered plan as described in Section 315 of these rules. (7-1-16)

318. HCBS TRANSITION PLAN.

As required by the Department, all current providers of HCBS must complete a Department-approved self assessment form related to the setting requirements and qualities described in Sections 311 through 314 of these rules. (7-1-16)

01. Provider Transition Plan. As part of the self-assessment process, providers not in compliance with any portion of the new requirements and qualities must develop a plan for coming into compliance. Self-assessment forms are subject to review and validation by the Department via quality assurance activities. (7-1-16)

02. New HCBS Providers or Service Settings. New HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. (7-1-16)

03. Quality Assurance. The Department will begin enforcement of quality assurance compliance with Sections 311 through 314 of these rules on January 1, 2017. (7-1-16)

319. HCBS -- TERMINATION OF PARTICIPANT ENROLLMENT.

01. Federal and State Eligibility Requirements. To be enrolled in an HCBS waiver or State Plan option program as provided in 42 CFR 441 and Section 1915 of the Social Security Act, a participant must meet the following eligibility requirements that include: (4-11-19)

a. An independent assessment; (4-11-19)

b. A state-approved person-centered plan; (4-11-19)

c. At least an annual redetermination of eligibility; and (4-11-19)

d. Other state-established criteria for determining eligibility under the State Plan for medical assistance. (4-11-19)

02. Failure to Meet Requirements. A participant who fails to meet any of the conditions of participation required by state established eligibility criteria is subject to termination of enrollment. (4-11-19)

03. Conditions for Termination of Enrollment. The Department will terminate the enrollment of a participant who is enrolled in an HCBS waiver or State Plan option, or who has accessed Medicaid coverage through an HCBS waiver or State Plan option under any of the following conditions. The participant: (4-11-19)

a. Does not have an identified need for a waiver or State Plan option service; (4-11-19)

b. Elects not to use services offered under the HCBS waiver or State Plan option; (4-11-19)

c. Declines to engage in person-centered planning; (4-11-19)

d. Does not meet other HCBS requirements provided in Section 319.01 of this rule; or (4-11-19)

e. Is non-responsive to three or more contact attempts by the Department or its designee to engage the participant in fulfilling requirements. (4-11-19)

04. Continuous Eligibility for Children Under Age Nineteen. Continuous health care assistance eligibility for children under age nineteen (19), as provided in IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," does not apply for a participant under the age of nineteen (19) who is enrolled in an HCBS waiver or State Plan option program or who has accessed Medicaid coverage through an HCBS waiver or State Plan option program. (4-11-19)

320. AGED AND DISABLED WAIVER SERVICES.

01. Description of Aged and Disabled Services. Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the consumer's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. (3-13-20)T

02. Temporary Changes to Aged and Disabled Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Aged and Disabled waiver services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver or HCBS Attachment K amendment to the existing Aged and

Disabled waiver. In the event additional changes are required in the future, guidance will be posted on the https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx webpage. Changes already in affect at the time of this rulemaking supersede existing rule and include: (3-13-20)T

a. Criminal History Background Checks. (Amends Subsections: 009.03.b., 009.03.k., 009.03.l., 329.03.c., 329.07, 329.09, 329.12.d., 329.14, 329.15, 329.17.a.vi., 329.18, 329.19.d., 329.20, 329.21.c.) Newly hired direct care staff may begin rendering services prior to a completed criminal history background check as long as all of the conditions in https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA2015.pdf are met. (3-13-20)T

b. Direct Care Staff Training Requirements. (Amends Subsections: 329.03, 329.10.f., 329.12.g., 329.13.c., 329.14, 329.15, 329.17.a. through d., 329.21.d.) Newly hired direct care staff may begin rendering services prior to the requirements associated with the provider's agency type or service array according to guidance in the https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA2015.pdf. (3-13-20)T

c. General Compliance and Oversight Activities. (Amends Sections: 328 and 329) Service providers may, at their discretion, implement the following changes to routine compliance and oversight activities according to guidance in the https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA2015.pdf. Allowable changes include: (3-13-20)T

i. Suspending supervisory on-sight visits. (3-13-20)T

ii. Suspending face-to-face service plan development. (3-13-20)T

iii. Utilizing telehealth to provide services. https://healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=xMwhG1MtoaI%3d&tabid=264&portalid=0&mid=18434 provides further guidance for providers able to use telehealth. (3-13-20)T

iv. Allowing alternative formats for signature requirements (such as electronic signatures). (3-13-20)T

v. Suspending the Department's on-site agency reviews. (3-13-20)T

d. Postponement of Annual Redeterminations. (Amends Subsection: 323.03) The Bureau of Long Term Care (BLTC) may postpone annual redeterminations at the discretion of the Department in order to prioritize workloads related to assessments for new waiver applicants and participants with significant changes. (3-13-20)T

321. AGED AND DISABLED WAIVER SERVICES: DEFINITIONS.
The following definitions apply to Sections 320 through 330 of these rules: (3-19-07)

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (3-19-07)

02. Individual Service Plan. A document that outlines all services including activities of daily living (ADL) and instrumental activities of daily living (IADL), required to maintain the individual in their home and community. The plan is initially developed by the Department or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the Department or its contractor, and all Medicaid reimbursable services must be contained in the plan. (4-4-13)

03. Personal Assistance Agency or Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll, including all required withholding for federal and state tax purposes, and benefits for care providers working for them. They also bill Medicaid for services provided by employees, and collect participant contribution. (3-19-07)

04. Employer of Record. An entity that bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary agency. (5-8-09)

05. Employer of Fact. A participant or representative of a participant who hires, fires, and directs the

services delivered by a waiver program provider. This individual may be a family member. (3-19-07)

06. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (3-19-07)

322. AGED AND DISABLED WAIVER SERVICES: ELIGIBILITY.
The Department provides waiver services to eligible participants: to prevent unnecessary institutional placement; to provide for the greatest degree of independence possible; to enhance the quality of life; to encourage individual choice; and to achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant: (3-19-07)

01. Has a Disabling Condition. Requires services due to a disabling condition that impairs their mental or physical function or independence; and (3-19-07)

02. Safe in a Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and (3-19-07)

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility. (4-2-08)

04. Functional Level for Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department or its contractor. In determining need for nursing facility care an adult must require the level of assistance listed in Subsections 322.04 through 322.07 of this rule, according to the formula described in Subsection 322.08 of this rule. (4-4-13)

05. Critical Indicator - 12 Points Each. (4-2-08)

a. Total assistance with preparing or eating meals. (4-2-08)

b. Total or extensive assistance in toileting. (4-2-08)

c. Total or extensive assistance with medications that require decision making prior to taking, or assessment of efficacy after taking. (4-2-08)

06. High Indicator - 6 Points Each. (4-2-08)

a. Extensive assistance with preparing or eating meals. (4-2-08)

b. Total or extensive assistance with routine medications. (4-2-08)

c. Total, extensive or moderate assistance with transferring. (4-2-08)

d. Total or extensive assistance with mobility. (4-2-08)

e. Total or extensive assistance with personal hygiene. (4-2-08)

f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). (4-2-08)

07. Medium Indicator - 3 Points Each. (4-2-08)

a. Moderate assistance with personal hygiene. (4-2-08)

b. Moderate assistance with preparing or eating meals. (4-2-08)

c. Moderate assistance with mobility. (4-2-08)

d. Moderate assistance with medications. (4-2-08)

e. Moderate assistance with toileting. (4-2-08)

f. Total, extensive, or moderate assistance with dressing. (4-2-08)

g. Total, extensive or moderate assistance with bathing. (4-2-08)

h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. (4-2-08)

08. Nursing Facility Level of Care, Adults. In order to qualify for nursing facility level of care, the individual must score twelve (12) or more points in one (1) of the following ways. (4-2-08)

a. One (1) or more critical indicators = Twelve (12) points. (4-2-08)

b. Two (2) or more high indicators = Twelve (12) points. (4-2-08)

c. One (1) high and two (2) medium indicators = Twelve (12) points. (4-2-08)

d. Four (4) or more medium indicators = Twelve (12) points. (4-2-08)

323. AGED AND DISABLED WAIVER SERVICES: PARTICIPANT ELIGIBILITY DETERMINATION.

Waiver eligibility will be determined by the Department or its contractor. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." In addition, waiver participants must meet the following requirements. (4-4-13)

01. Requirements for Determining Participant Eligibility. The Department or its contractor must determine that: (4-4-13)

a. The participant would qualify for nursing facility level of care under Sections 222 and 223 of these rules**,** if the waiver services listed in Section 326 of these rules were not made available; and (3-19-07)

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. Prior to any denial of services on this basis, the Department or its contractor must verify that services to correct the concerns of the team are not available. (3-20-20)

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of nursing facility care. (3-19-07)

d. Following the approval by the Department or its contractor for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (4-4-13)

02. Admission to a Nursing Facility. A participant who is determined by the Department or its contractor to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a nursing facility. (4-4-13)

03. Redetermination Process. Case Redetermination will be conducted by the Department or its contractor. The redetermination process will verify that the participant continues to meet nursing facility level of care and the participant's continued need for waiver services. (4-4-13)

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 and certified family homes. 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 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 individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (4-4-13)

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, a developmental disabilities agency, a residential care or assisted living facility, 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)

327. AGED AND DISABLED WAIVER SERVICES: PLACE OF SERVICE DELIVERY.

01. **Place of Service Delivery**. Waiver services may be provided in the participant's: (3-19-07)

a. Personal residence; (3-19-07)

b. Employment program; or (3-19-07)

c. Community. (3-19-07)

02. **Excluded Living Situations**. Living situations specifically excluded as a personal residence are: (3-19-07)

a. Skilled, or Intermediate Care Facilities; (3-19-07)

b. Nursing Facility; (3-19-07)

c. Licensed Intermediate Care Facility for the Persons with Intellectual Disabilities (ICF/ID); and (3-19-07)

d. Hospitals. (3-19-07)

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 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 Plan of Care. All services that are provided must be based on a written plan of care. (3-30-07)

a. The plan of care is developed by the plan of care team 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 written 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 the participant's living arrangement unless authorized to be kept elsewhere by the Department. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (4-4-13)

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

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

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

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)

11. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. **COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-13-20)T

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)

331. -- 349. (RESERVED)

350. TRANSITION MANAGEMENT.
Transition management provides relocation assistance and intensive service coordination activities to assist nursing facility, hospital, IMD and ICF/ID residents to transition to community settings of their choice. Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community. This provider type will function as a liaison between the participant, institutional or facility discharge staff, other individuals as designated by the participant and the Department to support a successful and sustainable transition to the community. A participant is eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) Medicaid-reimbursed days. (4-11-19)

01. **Provider Qualifications**. Transition managers must: (4-11-19)

a. Satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; (4-11-19)

b. Have documented successful completion of the Department approved Transition Manager training prior to providing any transition management and transition services; (4-11-19)

c. Have a Bachelor's Degree in a human services field from a nationally accredited university or college; or three (3) years' supervised work experience with the population being served; and (4-11-19)

d. Be employed with a provider type approved by the Department. (4-11-19)

02. **Service Description**. Transition management includes the following activities: (4-11-19)

a. A comprehensive assessment of health, social, and housing needs; (4-11-19)

b. Development of housing options with each participant, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; (4-11-19)

c. Assistance with tasks necessary to accomplish a move from the institutional setting; (4-11-19)

d. Securing Transition Services in accordance with Subsection 326.17 or Subsection 703.15 of these rules in order to make arrangements necessary to move, including: (4-11-19)

i. Obtaining durable medical equipment, assistive technology, and medical supplies, if needed; (4-11-19)

ii. Arranging for home modifications, if needed; (4-11-19)

iii. Applying for public assistance, if needed; (4-11-19)

iv. Arranging household preparations including scheduling moving and/or cleaning services, utility set-up, purchasing furniture, and household supplies, if needed; (4-11-19)

e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; (4-11-19)

f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, Post Secondary Educational Institutions & Proprietary Schools when applicable, and community inclusion. (4-11-19)

03. **Service Limitations**. Transition management is limited to seventy-two (72) hours per participant per qualifying transition. (4-11-19)

04. **Temporary Changes to Transition Management Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Transition Management services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. Changes already in affect at the time of this rulemaking supersede existing rule and include: (3-13-20)T

a. Criminal History Background Checks. (Amends Subsection: 350.01.a.) Newly hired direct care staff may begin rendering services prior to a completed criminal history background check as long as all of the conditions in Medicaid Information Release MA20-15 are met. (3-13-20)T

b. General Compliance and Oversight Activities. (Amends Subsection: 350.02) Service providers

may, at their discretion, implement the following changes to routine compliance and oversight activities according to guidance in the Medicaid Information Release MA20-15. Allowable changes include: (3-13-20)T

i. Suspending face-to-face service plan development. (3-13-20)T

ii. Utilizing telehealth to provide services. Medicaid Information Release MA20-07 provides further guidance for providers able to use telehealth. (3-13-20)T

iii. Allowing alternative formats for signature requirements (such as electronic signatures). (3-13-20)T

351. -- 449. (RESERVED)

SUB AREA: HOSPICE
(Sections 450-459)

450. HOSPICE.
Medical assistance will provide payment for hospice services for eligible participants. Reimbursement will be based on Medicare program coverage as set out in Sections 450 through 456 of these rules. (3-19-07)

451. HOSPICE: DEFINITIONS.
The following definitions apply to Sections 450 through 456 of these rules. (3-19-07)

01. Attending Physician. A physician who: (3-19-07)

a. Is a doctor of medicine or osteopathy; and (3-19-07)

b. Is identified by the participant, at the time they elect to receive hospice care, as having the most significant role in the determination and delivery of the participant's medical care. (3-19-07)

02. Benefit Period. A period of time that begins on the first day of the month the participant elects hospice and ends on the last day of the eleventh successive calendar month. (3-19-07)

03. Bereavement Counseling. Counseling services provided to the participant's family after the participant's death. (3-19-07)

04. Cap Amount. The maximum amount of reimbursement the Idaho Medicaid Program will pay a designated hospice for providing services to Medicaid participants per Section 459 of these rules. (3-19-07)

05. Cap Period. The twelve (12) month period beginning November 1 and ending October 31 of the next year. See overall hospice reimbursement cap referred to in Section 459 of these rules. (3-19-07)

06. Election Period. One (1) of eight (8) periods within the benefit period that an participant may elect to receive Medicaid coverage of hospice care. Each period consists of any calendar month, or portion thereof, chosen within the benefit period. (3-19-07)

07. Employee. An individual serving the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization that is appropriately trained and assigned to the hospice unit. Employee also refers to a volunteer under the jurisdiction of the hospice. (3-19-07)

08. Freestanding Hospice. A hospice that is not part of any other type of participating provider. (3-19-07)

09. Hospice. A public agency or private organization or a subdivision that: (3-19-07)

a. Is primarily engaged in providing care to terminally ill participants; and (3-19-07)

b. Meets the conditions specified for certification for participation in the Medicare and Medicaid

programs and has a valid provider agreement. (3-19-07)

10. **Independent Physician**. An attending physician who is not an employee of the hospice. (3-19-07)

11. **Representative**. A person who is, because of the participant's mental or physical incapacity, legally authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill participant. (3-19-07)

12. **Social Worker**. A person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education. (3-19-07)

13. **Terminally Ill**. When a participant has a certified medical prognosis that life expectancy is six (6) months or less per Subsection 454.01 of these rules. (3-19-07)

452. HOSPICE: ELIGIBILITY.

Inherent in the Hospice program is that a participant understands the nature and basis for eligibility for hospice care without an inappropriate and explicit written statement about how the impending death will affect care. Though only written acknowledgment of the election periods is mandated, it is required that the participant or their representative be fully informed by a hospice before the beginning of a participant's care about the reason and nature of hospice care. The following are the eligibility requirements for Hospice: (3-19-07)

01. **Certification**. A certification that the participant is terminally ill must have been completed in accordance with Section 454.01 of these rules. (3-19-07)

02. **Medically Necessary**. Hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. (3-19-07)

03. **Election of Services**.The participant must elect hospice care in accordance with Section 454.02 of these rules**.** (3-19-07)

453. HOSPICE: COVERAGE REQUIREMENTS AND LIMITATIONS.

The following services are required: (3-19-07)

01. **Nursing Care**. Nursing care provided by or under the supervision of a licensed registered nurse. (3-19-07)

02. **Medical Social Services**. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. (3-19-07)

03. **Physician Services**. Physician's services performed by a physician as defined in Subsection 451.01 of these rules. (3-19-07)

04. **Counseling Services**. Counseling services provided to the terminally ill participant and the family members or other persons caring for the participant at home. Counseling, including bereavement and dietary counseling, are core hospice services provided both for the purpose of training the participant's family or other caregiver to provide care, and for the purpose of helping the participant and those caring for them to adjust to the participant's approaching death. (3-19-07)

05. **Inpatient Care**. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, or a nursing facility that additionally meets the hospice standards regarding staff and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the participant's family or other persons caring for the participant at home. (3-19-07)

06. **Medical Equipment and Supplies**. Medical equipment and supplies include drugs and

biologicals. Only drugs as defined in Subsection 1861(t) of the Social Security Act and that are used primarily for the relief of pain and symptom control related to the patient's terminal illness are required. Appliances include durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while they are under hospice care. Medical supplies include only those that are part of the written plan of care. (3-19-07)

07. Home Health Services. Home health aide and homemaker services furnished by qualified aides. Home health aides will provide personal care services and will also perform household services necessary to maintain a safe and sanitary environment in areas of the home used by the patient. Aide services must be provided under the general supervision of a licensed registered nurse. Homemaker services include assistance in maintenance of a safe and healthy environment and services to enable the participant to carry out the plan of care. (3-19-07)

08. Therapies. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the participant to maintain activities of daily living and basic functional skills. (3-19-07)

09. Core Services. Nursing care, physician's services, medical social services, and counseling are core hospice services and must be routinely provided by hospice employees. Supplemental core services may be contracted for during periods of peak patient loads and to obtain physician specialty services. (3-19-07)

454. HOSPICE: PROCEDURAL REQUIREMENTS.

01. Physician Certification. The hospice must obtain the certification that a participant is terminally ill in accordance with the following procedures: (3-19-07)

a. For the first period of hospice coverage, the hospice must obtain, no later than two (2) calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the participant's attending physician (if the participant has one). The certification must include the statement that the participant's medical prognosis is that their life expectancy is six (6) months or less and the signature(s) of the physician(s). In the event the participant's medical prognosis or the appropriateness of hospice care is questionable, the Department has the right to obtain another physician's opinion to verify a participant's medical status. (3-19-07)

b. For any subsequent election period, the hospice must obtain, no later than two (2) calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the interdisciplinary group. The certification must include the statement that the participant's medical prognosis is that their life expectancy is six (6) months or less and the signature(s) of the physician(s). (3-19-07)

c. The hospice must maintain the monthly certification statements for review. (3-19-07)

d. The hospice will submit a physician listing with their provider application and update changes in the listing of physicians that are hospice employees, including physician volunteers, to the Bureau of Facility Standards. The designated hospice must also notify the Medicaid program when the designated attending physician of a participant in their care is not a hospice employee. (3-19-07)

02. Election Procedures. If an participant elects to receive hospice care, they must file an election statement with a particular hospice. An election statement may also be filed by a legal representative or guardian per Section 15-5-312, Idaho Code. (3-19-07)

a. An election to receive hospice care will be automatically renewed after the initial election period and through any subsequent election periods without a break in care as long as the participant remains in the care of a designated hospice and does not revoke the election. (3-19-07)

b. A participant who elected less than eight (8) monthly election periods within the benefit period may request the availability of the remaining election periods. When the following conditions are met, the request will be granted. (3-19-07)

i. The hospice days available did not exceed two hundred ten (210) days in the benefit period due to the loss of financial eligibility. (3-19-07)

ii. The participant or the legal representative did not change hospices excessively per Subsection 454.05 of these rules. (3-19-07)

iii. The participant or the legal representative did not revoke hospice election periods more than eight (8) times per Subsection 454.04 of these rules. (3-19-07)

c. A participant may receive hospice services from the first day of hospice care or any subsequent day of hospice care, but a participant cannot designate an effective date that is earlier than the date that the election is made. (3-19-07)

d. A participant must waive all rights to Medicaid payments for the duration of the election period of hospice care, with the following exceptions: (3-19-07)

i. Hospice care and related services provided either directly or under arrangements by the designated hospice to the participant. (3-19-07)

ii. Any Medicaid services that are not related or equivalent to the treatment of the terminal condition or a related condition for which hospice care was elected. (3-19-07)

iii. Physician services provided by the participant's designated attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. (3-19-07)

03. Election of Hospice. The election statement must include the following items of information: (3-19-07)

a. Identification of the particular hospice that will provide care to the participant. (3-19-07)

b. The participant's or representative's acknowledgment that they have been given a full understanding of hospice care. (3-19-07)

c. The participant's or representative's acknowledgment that they understand that all Medicaid services except those identified in Subsection 454.02.d. of these rules, are waived by the election during the hospice benefit period. (3-19-07)

d. The effective date of the election. (3-19-07)

e. The signature of the participant or the representative and the date of that signature. (3-19-07)

04. Revocation of Hospice Election. A participant or representative may revoke the election of hospice care at any time. (3-19-07)

a. To revoke the election of hospice care, the participant must file a signed statement with the hospice that includes that the participant revokes the election for Medicaid coverage of hospice care effective as of the date of the revocation. (3-19-07)

b. Upon revocation of the hospice election, other Medicaid coverage is reinstated. (3-19-07)

05. Change of Hospice. A participant may at any time change their designated hospice during election periods for which they are eligible. (3-19-07)

a. A participant may change designated hospices no more than six (6) times during the hospice benefit period. (3-19-07)

b. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the participant must file during the monthly election period, with the hospice from which they have received care and with the newly designated hospice, a dated and signed statement that includes the following information: (3-19-07)

i. The name of the hospice from which the participant has received care; (3-19-07)

ii. The name of the hospice from which they plan to receive care; and (3-19-07)

iii. The effective date of the change in hospices. (3-19-07)

c. A change in ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part. (3-19-07)

06. Plan of Care. A plan of care must be established and reviewed at least monthly. To be covered, services must be consistent with the plan of care. (3-19-07)

a. In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one (1) other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. (3-19-07)

b. At least one (1) of the persons involved in developing the initial plan must be a nurse or a physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. (3-19-07)

c. The other two (2) members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two (2) calendar days following the day of assessment; input may be provided by telephone. (3-19-07)

455. HOSPICE: PROVIDER QUALIFICATIONS AND DUTIES.
All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the category of the service. (3-19-07)

456. HOSPICE: PROVIDER REIMBURSEMENT.
With the exception of payment for physician services under Section 458 of these rules, Medicaid reimbursement for hospice care will be made at one (1) of five (5) predetermined rates for each day in which a participant receives the respective type and intensity of the services furnished under the care of the hospice. The five (5) rates are prospective rates; there will be no retroactive rate adjustments other than the application of the "cap" on overall payments, the service intensity add-on, and the limitation on payments for inpatient care, if applicable. A description of the payment for each level of care is described in Subsections 456.01 through 456.04 of these rules. (3-29-17)

01. Routine Home Care. The hospice provider will be paid one (1) of two (2) routine home care rates for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. The rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The two-rate payment methodology will result in a higher based payment for days one (1) through sixty (60) of hospice care and a reduced rate for days sixty-one (61) to end-of-care. If a participant leaves hospice care and then later is placed back on hospice care, regardless of hospice provider, a minimum of a sixty (60) day gap in hospice services is required in order for the routine home care rate to be paid at the higher base payment rate. If there is not a minimum of a sixty (60) day gap in hospice services being provided, the hospice provider will be paid at the rate for which the participant is qualified. (3-29-17)

02. Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care that is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a licensed registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the

person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day. (3-19-07)

03. Inpatient Respite Care. The hospice will be paid at the inpatient respite care rate for each day that the participant is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine, continuous, or general inpatient rate. (3-19-07)

04. General Inpatient Care. Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the participant receives hospice general inpatient care except as described in Section 458 of these rules. (3-19-07)

a. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date. (3-19-07)

b. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid participants. (3-19-07)

c. Obligation of continuing care. After the participant's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that participant's care until the patient expires or until the participant revokes the election of hospice care. (3-19-07)

05. Service Intensity Add-On. For hospice services with dates of service on and after January 1, 2016, a service intensity add-on payment will be made for a visit by a licensed registered nurse (RN) or social worker when provided in the last seven (7) days of life. Payment for the service intensity add-on is in addition to the routine home care rate and is calculated by multiplying the continuous home care rate per fifteen (15) minutes by the number of units for the combined visits for the day. Payment must not exceed sixteen (16) units per day, and is adjusted for geographic differences in wages. Phone time for a provider's social worker is not eligible for a service intensity add-on payment. (3-29-17)

457. HOSPICE: LIMITATION ON PAYMENTS FOR INPATIENT CARE.
Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1st of each year and ending October 31st of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid participants during the same period by the designated hospice or its contracted agent(s). (3-19-07)

01. For Purposes of Computation. If it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows: (3-19-07)

a. The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%). (3-19-07)

b. If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed in Subsection 457.01 of these rules then no adjustment is made. (3-19-07)

c. If the total number of days of inpatient care exceeds the maximum number of allowable inpatient days computed in Subsection 457.01 of these rules then the payment limitation will be determined by: (3-19-07)

i. Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made. (3-19-07)

ii. Multiplying excess inpatient care days by the routine home care rate. (3-19-07)

iii. Adding the amounts calculated in Subsections 457.01.c.i. and 457.01.c.ii. of these rules. (3-19-07)

iv. Comparing the amount in Subsection 457.01.c.iii. of these rules with interim payments made to the hospice for inpatient care during the "cap period." (3-19-07)

02. The amount by which interim payments for inpatient care exceeds the amount calculated as in Section 459 of these rules is due from the hospice. (3-19-07)

458. HOSPICE: PAYMENT FOR PHYSICIAN SERVICES.
The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the participant's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. (3-19-07)

01. Hospice Employed Physician Direct Patient Service. Reimbursement for a hospice employed physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount per Section 459 of these rules has been exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and X-ray services are included in the hospice daily rate. (3-19-07)

02. Volunteer Physician Services. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions: (3-19-07)

a. A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services that are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay. (3-19-07)

b. Reimbursement for an independent physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount per Section 459 of these rules has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or X-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice. (3-19-07)

459. HOSPICE: CAP ON OVERALL REIMBURSEMENT.
Aggregate payments to each hospice will be limited during a hospice cap period per Subsection 451.05 of these rules. The total payments made for services furnished to Medicaid participants during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. (3-19-07)

01. Overall Cap. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice. (3-19-07)

02. Total Payment for Services. Total payment made for services furnished to Medicaid participants during this period means all payments for services rendered during the cap year, regardless of when payment is actually made. (3-19-07)

03. Calculation of Cap Amount. The "cap amount" is calculated by multiplying the number of participants electing certified hospice care during the period by six thousand five hundred dollars ($6,500). This amount will be adjusted for each subsequent cap year beginning November 1, 1983, to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers as published by the Bureau of Labor Statistics. It will also be adjusted as per Subsection 459.07 of these rules. (3-19-07)

04. Computation and Application of Cap Amount. The computation and application of the "cap amount" is made by the Department after the end of the cap period. (3-19-07)

05. Report Number of Medicaid Participants. The hospice must report the number of Medicaid participants electing hospice care during the period to the Department. (3-19-07)

a. This must be done within thirty (30) days after the end of the cap period: and (3-19-07)

b. If the participant is transferred to a non-certified hospice no payment to the non-certified hospice will be made and the certified hospice may count a complete participant benefit period in their cap amount. (3-19-07)

06. Certified in Mid-Month. If a hospice certifies in mid-month, a weighted average cap amount based on the number of days falling within each cap period would be used. (3-19-07)

07. Adjustment of the Overall Cap. Cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during a participant's election period. The proportion of each hospice's days of service to the total number of hospice days rendered to the participant during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount. (3-19-07)

a. After each cap period has ended, the Department will calculate the overall cap within a reasonable time for each hospice participating in the Idaho Medicaid Program. (3-19-07)

b. Each hospice's cap amount will be computed as follows: (3-19-07)

i. The share of the "cap amount" that each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period." (3-19-07)

ii. The proportion determined in Section 457 of these rules for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the participant first elected hospice. (3-19-07)

c. The participant must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year in order to be counted as an electing Medicaid participant during the current cap year. (3-19-07)

08. Additional Amount for Nursing Facility Residents. An additional per diem amount will be paid for "room and board" of hospice residents in a certified nursing facility receiving routine or continuous care services. In this context, the term "room and board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps specified in Sections 457 and 459 of these rules. The room and board rate will be ninety-five percent (95%) of the per diem interim reimbursement rate assigned to the facility for those dates of service on which the participant was a resident of that facility. (3-19-07)

460. HOSPICE: POST-ELIGIBILITY TREATMENT OF INCOME.
Where a participant is determined eligible for medical assistance participation in the cost of long term care, the Department will reduce its payments for all costs of the hospice benefit, including the supplementary amounts for room and board, by an amount determined according to Section 227 of these rules. (3-19-07)

461. -- 499. (RESERVED)

SUB PART: ENHANCED DEVELOPMENTAL DISABILITY SERVICES
(Sections 500-719)

500. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS.
Prior to receiving developmental disability services as provided in Sections 507 through 719 of these rules, the participant must be determined to have a developmental disability. (3-19-07)

501. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS: ELIGIBILITY.
The definitions and standards in the table below must be used to determine whether a participant meets criteria as a person with a developmental disability under Section 66-402, Idaho Code.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
"Developmental Disability" means a chronic disability of a person that appears before the age of 22 years and:	Age of 22 means through the day before the individual's 22nd birthday. AND
(a) is attributable to an impairment, such as an intellectual disability;	"Is attributable to an impairment" means that there is a causal relationship between the presence of an impairing condition and the developmental disability. **Age 5 through Adult:** There is a presumption that an intellectual disability exists when a full scale IQ score up to 75 exists. (IQ of 70 with a standard error of measurement of 5 points.) **Birth to Age 5:** An IQ test score is not required below the age of 5. In these cases it may be necessary to rely on the results of a functional assessment. There is a presumption that an intellectual disability exists when there is a standard score of 75 or below or a delay of 30% overall.
cerebral palsy;	Medical Diagnosis that requires documentation.
epilepsy;	Medical Diagnosis that requires documentation. On medication controlled or uncontrolled. Does not include a person who is seizure-free and not on medication for 3 years.
autism;	Includes the diagnosis of pervasive developmental disorder.
or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services;	For related or similar conditions, documentation must be present to show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness) **Intellectual Disability:** A full scale IQ score above 75 can in some circumstances be considered a related or similar condition to an intellectual disability when additional supporting documentation exists showing how the individual's functional limitations make their condition similar to an intellectual disability. **Cerebral Palsy:** Conditions related or similar to cerebral palsy include disorders that cause a similar disruption in motor function. **Epilepsy:** Conditions related or similar to epilepsy include disorders that interrupt consciousness.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
or is attributable to dyslexia resulting from such impairments; and	AND
(b) results in substantial functional limitations in three (3) or more of the following major life activities:	"Results in" means that the substantial limitation must be because of the impairment. A "substantial" limitation is one in which the total effect of the limitation results in the need for a "combination and sequence of special interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated." Listed below are standards for substantial functional limitations in each major life area. **Age 3 through Adult:** A score of 2 standard deviations below the mean creates a presumption of a functional limitation. **Birth to Age 3:** The following criteria must be utilized to determine a substantial functional limitations for children under 3: **a.** The child scores 30% below age norm; or **b.** The child exhibits a 6 month delay; or **c.** The child scores 2 standard deviations below the mean.
self care;	**Adult:** A substantial functional limitation is manifest when the person requires physical or non-physical assistance in performing eating, hygiene, grooming, or health care skills, or when the time required for a person to perform these skills him/her self is so substantial as to impair their ability to conduct other activities of daily living or retain employment. **Birth to Age 21:** A functional limitation is manifest when the child's skills are limited according to age-appropriate responses such that the parent, caregiver, or school personnel is required to provide care that is substantially beyond that typically required for a child of the same age (such as excessive time lifting, diapering, supervision).
receptive and expressive language;	**Age 3 through Adult:** A substantial functional limitation is manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). **Birth to Age 3:** A substantial functional limitation is manifest when they have been diagnosed by a qualified professional who determines that the child performs 30% below age norm (adjusted for prematurity up to 2 years) or demonstrates at least 2 standard deviations below the mean in either area or 1 1/2 below in both areas of language development.
learning;	**Birth through Adult:** A substantial functional limitation is manifest when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that special (interventions that are beyond those that an individual normally needs to learn) intervention is required for the development of social, self care, language, academic, or vocational skills.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
mobility;	**Adult:** A substantial functional limitation is manifest when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. **Birth to Age 21:** A substantial limitation would be measured by an age appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with those skills expected of children of the same age.
self-direction;	**Adult:** A substantial functional limitation is manifest when a person requires assistance in managing their personal finances, protecting their self interest, or making decisions that may affect their well being. **Birth to Age 21:** A substantial limitation is manifest when the child is unable to help themself or cooperate with others age appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments.
capacity for independent living; or	**Adult:** A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. **Birth to Age 21:** A substantial limitation would be measured by an age-appropriate instrument that compares the child's personal independence and social responsibility expected of children of comparable age and cultural group.
economic self-sufficiency; and	**Adult:** A substantial functional limitation is manifest when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. **Age 5 to Age 21:** Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. **Birth to Age 5:** A substantial limitation in this area is evidenced by the child's eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). AND
(c) reflects the needs for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated.	**Age 5 through Adult:** Life-long or extended duration means the developmental disability is one that has the reasonable likelihood of continuing for a protracted period of time, including a reasonable likelihood that it will continue throughout life. **Birth to Age 5:** The expected duration may be frequently unclear. Therefore, determination of eligibility by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP will be an indicator of this criteria.

(3-19-07)

502. (RESERVED)

503. DEVELOPMENTAL DISABILITY DETERMINATION: TEST INSTRUMENTS.
A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (3-19-07)

01. Test Instruments For Adults. A Department-approved assessment tool for conducting cognitive and functional assessments must be used to determine eligibility. (7-1-18)

02. Test Instruments for Children. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills. A Department-approved assessment tool for conducting cognitive and functional assessments must be used with children. (7-1-18)

504. -- 506. (RESERVED)

507. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION (PA).
The purpose of adult developmental disability services prior authorization is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. (3-29-12)

508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. (3-29-12)

01. Adult. A person who is eighteen (18) years of age or older. (3-29-10)

02. Assessment. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)

03. Clinical Review. A process of professional review that validates the need for continued services. (3-19-07)

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-19-07)

06. Department-Approved Assessment Tool. Any standardized assessment tool approved by the Department for use in determining developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant’s budget. (7-1-18)

07. Exception Review. A clinical review of a plan that falls outside the established standards. (3-19-07)

08. Interdisciplinary Team. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)

09. Level of Support. An assessment score derived from a Department-approved assessment tool that

indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (7-1-18)

10. **Person-Centered Planning Process**. A meeting facilitated by the participant or plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (7-1-16)

11. **Person-Centered Planning Team**. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)

12. **Plan Developer**. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)

13. **Plan Monitor**. A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)

14. **Plan of Service**. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)

15. **Prior Authorization (PA)**. A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)

16. **Provider Status Review**. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

17. **Right Care**. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)

18. **Right Place**. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)

19. **Right Price**. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)

20. **Right Outcomes**. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)

21. **Service Coordination**. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)

22. **Service Coordinator**. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)

23. **Services**. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

24. **Supports**. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of their choice. (3-19-07)

509. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: ELIGIBILITY DETERMINATION.
The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments will be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/ID level of care for waiver services in accordance with Section 584 of these rules. (3-29-12)

01. Initial Assessment. For new applicants, an assessment will be completed within thirty (30) days from the date a completed application is submitted. (3-19-07)

02. Annual Assessments. Assessments will also be completed for current participants at the time of their annual eligibility redetermination. The assessor will evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (3-19-07)

a. The assessment process will be completed; and (3-19-07)

b. The assessor will provide the results of the assessment to the participant. (3-19-07)

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services will include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. A Department-approved assessment tool will be administered by the Department for use in this determination. (7-1-18)

04. ICF/ID Level of Care Determination for Waiver Services. The assessor will determine ICF/ID level of care for adults in accordance with Section 584 of these rules. (3-19-07)

510. (RESERVED)

511. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid developmental disability services for adults: (3-29-12)

01. DD Waiver Services. DD Waiver services as described in Sections 700 through 719 of these rules; and (3-29-10)

02. Developmental Therapy. Developmental therapy as described in Sections 649 through 657 of these rules and IDAPA 16.03.21, “Developmental Disabilities Agencies (DDA)”; and (7-1-13)

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

512. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of

service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-29-10)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

03. Medical, Social, and Developmental History. The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of developmental therapy and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. (7-1-13)

a. A medical, social and developmental history for each adult participant is completed by the Department or its contractor. (7-1-13)

b. Providers should obtain and utilize the medical, social developmental history documents generated by the Department or its contractor when one is necessary for adult program or plan development. (7-1-13)

04. Department-Approved Assessment Tool. The results of a Department-approved assessment tool are used to determine the level of support for the participant. A current Department-approved assessment will be evaluated prior to the initiation of service and reviewed annually to assure it continues to reflect the functional status of the participant. A department-approved assessment tool for adults is completed by the Department or its contractor. Providers must obtain and utilize the document generated by the Department or its contractor when one is necessary for program or plan development. (7-1-18)

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (3-19-07)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.

In collaboration with the participant, the Department will assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-29-12)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. All participants must direct the development of their service plan through a person-centered planning process. Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes. (7-1-16)

a. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (7-1-16)

b. The plan development process must meet the person-centered planning requirements described in Section 316 of these rules. (7-1-16)

c. The participant may facilitate their own person-centered planning meeting, or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant. (7-1-16)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-19-07)

a. Durable Medical Equipment (DME); (3-19-07)

b. Transportation; and (3-19-07)

c. Physical therapy, occupational therapy, and speech-language pathology services. (7-1-13)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-29-12)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code; (3-13-20)T

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews. (3-29-12)

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-29-12)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.09 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (7-1-16)

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-19-07)

a. The written plan of service must meet the person-centered planning requirements described in

Section 317 of these rules. (7-1-16)

b. The written plan of service must be finalized and agreed to according to procedural requirements described in Section 704 of these rules. (7-1-16)

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other developmental disability service provider identified by the participant during the person-centered planning process. (7-1-16)

08. Informed Consent. Unless the participant has a guardian who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with members of the planning team. (7-1-16)

09. Provider Implementation Plan. Each provider of Medicaid services must develop an implementation plan that complies with home and community-based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service. (7-1-16)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental accessibility adaptations; (7-1-16)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. Implementation plans must be completed within fourteen (14) days of receipt of the authorized plan of service or the service start date, whichever is later. (7-1-16)

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. (7-1-16)

ii. Implementation plan revision must be based on changes to the needs of the participant. (7-1-16)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. (3-19-07)

10. Home and Community-Based Services Plan of Service Signature. Upon receipt of the

authorized plan of service, HCBS providers responsible for the implementation of the plan as identified in Section 317 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community-based requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Documentation of signature must include the signature of the professional responsible for service provision complete with their title and the date signed. Provider signature will be completed each time an initial or annual plan of service is implemented. (7-1-16)

11. Addendum to the Plan of Service. (7-1-16)

a. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (7-1-16)

b. When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service as identified in Section 317 of these rules. (7-1-16)

c. Upon receipt of the addendum, the HCBS provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision complete with their title and the date signed, and must be maintained in the participant's record. Provider signature will be completed each time an addendum is authorized. (7-1-16)

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department will review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.06 of these rules. (7-1-16)

iii. Convene the person-centered planning team to develop a new plan of service; inviting individuals to participate that have been identified by the participant. (7-1-16)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service will be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-29-12)

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.10 of these rules. (7-1-16)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor will evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment will be completed in accordance with Section 512 of these rules. (3-19-07)

13. Complaints and Administrative Appeals. (3-29-12)

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (3-29-12)

b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-29-12)

514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. (3-29-12)

01. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-29-12)

a. The Department notifies each participant of their set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-29-12)

b. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. (3-29-12)

02. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and they are less dependent on supports, they must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision as determined by a Department-approved assessment tool. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (7-1-18)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender

risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-19-07)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-19-07)

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may take enforcement actions as described in IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation. (7-1-16)

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, participant experience related to home and community-based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (7-1-16)

03. Exception Review. The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following conditions are met: (4-11-15)

a. Services are needed to assure the health or safety of participants and the services requested on the plan or addendum are required based on medical necessity as defined in Section 012 of these rules. (3-28-18)

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: (4-11-15)

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; (4-11-15)

ii. The participant's plan of service was developed by the participant and their person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's combination of services must support the increase or addition of supported employment services; and (4-11-15)

iii. An acknowledgment signed by the participant and their legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. (4-11-15)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. (7-1-16)

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-19-07)

516. -- 519. (RESERVED)

SUB-PART: CHILDREN'S DEVELOPMENTAL DISABILITIES (DD)
HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 520-528)

520. CHILDREN'S DD HCBS STATE PLAN OPTION.
In accordance with Section 1915(i) of the Social Security Act, the Department will pay for home and community-based services provided by individuals or agencies that have entered into a provider agreement with the Department. (3-20-20)

521. CHILDREN'S DD HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of Sections 520 through 528 of these rules, the following terms are used as defined below. (3-20-20)

01. Annual. Every three hundred sixty-five (365) days, except during a leap year which equals three hundred sixty-six (366) days. (3-20-20)

02. Community. Natural, integrated environments outside of the participant's home, outside of DDA center-based settings, or at school outside of school hours. (3-20-20)

03. Developmental Disabilities Agency (DDA). (3-20-20)

a. A type of developmental disabilities facility, as defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis; (3-20-20)

b. Certified by the Department to provide services to participants with developmental disabilities; and (3-20-20)

c. A business entity, open for business to the general public. (3-20-20)

04. Family-Centered Planning Process. A participant-focused planning process directed by the participant or the participant's decision-making authority and facilitated by the paid or non-paid plan developer. The

family-centered planning team discusses the participant's strengths, needs, and preferences, including the participant's safety and the safety of those around the participant. This discussion helps the participant or the participant's decision-making authority make informed choices about the services and supports included on the plan of service. (7-1-16)

05. Family-Centered Planning Team. The planning group who helps inform the participant about available services to develop the participant's plan of service. This group includes, at a minimum, the participant, the participant's decision-making authority, and the plan developer. The family-centered planning team must include people chosen by the participant and the family. (3-20-20)

06. HCBS State Plan Option. The federal authority under Section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and participants with disabilities who without the provision of services the participants would require institutional level of care. (3-20-20)

07. Integration. The process of promoting a lifestyle for participants with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of participants with developmental disabilities. (3-20-20)

08. Level of Support. The amount of services and supports necessary to allow the participant to live independently and safely in the community. (3-20-20)

09. Medical, Social, and Developmental Assessment Summary. A form used by the Department or its contractor to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. (3-20-20)

10. Plan Developer. A paid or non-paid person who, under the direction of the participant or the participant's decision-making authority, is responsible for developing a single plan of service and subsequent addenda. The plan of service must cover all services and supports identified during the family-centered planning process and must meet the HCBS person-centered plan requirements as described in Section 317 of these rules. (3-20-20)

11. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis and is identified on the participant's plan of service. (3-20-20)

12. Plan of Service. An initial or annual plan of service, developed by the participant, the participant's decision-making authority, and the family-centered planning team, that identifies all services that were determined through a family-centered planning process. Plan development is required in order to provide DD services to children from birth through seventeen (17) years of age. This plan must be developed in accordance with Sections 316 and 317 of these rules. (3-20-20)

13. Practitioner of the Healing Arts, Licensed. A licensed physician, physician assistant, or nurse practitioner. (7-1-11)

14. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as described in Sections 520 through 528 of these rules. (3-20-20)

15. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service, and demonstrates the continued need for the service. (7-1-11)

16. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (7-1-11)

17. Right Place. Services delivered in the most integrated setting in which they normally occur, based

on the participant's choice to promote independence. (7-1-11)

18. **Right Price**. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (7-1-11)

19. **Right Outcomes**. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-11)

20. **Supervisor**. An individual responsible for the supervision of DDA staff or independent providers that must meet the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits", Section 570. (3-20-20)

21. **Support Services**. Services that provide supervision and assistance to a participant or facilitates integration into the community. (3-20-20)

522. CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.
Final determination of a participant's eligibility will be made by the Department. (3-20-20)

01. **Initial Eligibility Assessment Developmental Disability Determination**. The Department, or its contractor, will determine if a child meets established criteria for a developmental disability by completing the following: (3-20-20)

a. Documentation of a participant's developmental disability diagnosis, demonstrated by: (3-20-20)

i. A medical assessment that contains medical information that accurately reflects the current status of the participant or establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code; or (3-20-20)

ii. The results of psychometric testing, if eligibility for developmental disabilities services is based on intellectual disability and there is no prior testing, or prior testing is inconclusive or invalid. Initial eligibility determinations also require documentation of diagnosis for a participant whose eligibility is based on developmental disabilities other than intellectual disability. (3-20-20)

b. An assessment of functional skills that reflects the participant's current functioning. The Department, or its contractor, will administer a functional assessment for use in initial eligibility determination of developmental disability eligibility. Annually, a new functional assessment may be required if the assessor determines that additional documentation is necessary to determine the participant's level of care criteria and must be completed sixty (60) calendar days before the expiration of the current plan of service. (3-20-20)

c. Medical, social, and developmental assessment (MSDA) summary. (3-20-20)

02. **Determination for Children's DD HCBS State Plan Option**. The Department, or its contractor, will determine if a child meets the established criteria necessary to receive children's DD HCBS state plan option services by verifying: (3-20-20)

a. The participant is birth through seventeen (17) years of age; and (3-20-20)

b. The participant has a developmental disability as defined under Sections 500, 501, and 503 these rules and Section 66-402, Idaho Code, and has a demonstrated need for Children's DD HCBS state plan option services; and (3-20-20)

c. The participant qualifies for Medicaid under an eligibility group who meets the needs-based criteria of the 1915(i) benefit for children with developmental disabilities and falls within the income requirements as specified in Attachment 2.2-A of the Idaho State Plan under Title XIX. (3-20-20)

03. **Individualized Budget Methodology**.

The following four (4) categories are used when determining individualized budgets for children with developmental disabilities. (3-20-20)

a. Children's DD - Level I. Children meeting developmental disabilities criteria. (3-20-20)

b. Children's DD - Level II. (3-20-20)

i. Children who qualify based on functional limitations when their composite full-scale standard score of less than fifty (50); or (3-20-20)

ii. Children who have an overall standard score up to fifty-three (53) when combined with a maladaptive behavior score of greater than one (1) to less than two (2) standard deviations from the mean. (3-20-20)

c. Children's DD - Level III. (3-20-20)

i. Children who qualify based on functional limitations when their composite full-scale standard score is less than fifty (50); and (3-20-20)

ii. Have an autism spectrum disorder diagnosis. (3-20-20)

d. Children's DD - Level IV. Children who qualify based on maladaptive behaviors when their maladaptive behavior score is two (2) standard deviations or greater from the mean. (3-20-20)

04. Participant Notification of Budget Amount. The Department, or its contractor, will notify each participant of his set budget amount as part of the eligibility determination process. The notification will include how the participant may appeal the set budget amount. (3-20-20)

05. Re-Evaluation. Individualized budgets will be re-evaluated. At the request of the participant, the Department, or its contractor, will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category as outlined in Subsection 522.03 of this rule. (3-13-20)T

523. CHILDREN'S DD HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
All children's DD HCBS must be identified on a plan of service developed by the family-centered planning team. The following services must be prior authorized and are reimbursable when provided in accordance with these rules. (3-20-20)

01. Respite. Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver or in response to a family emergency or crisis. Respite may be provided by a DDA or by an independent respite provider. An independent respite provider may be a relative of the participant. Payment for respite does not include room and board. Respite may be provided in the participant's home, the private home of the independent respite provider, a DDA, or in the community. The following limitations apply: (3-20-20)

a. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. (3-20-20)

b. Respite must only be offered to participants living with an unpaid caregiver who requires relief. (3-20-20)

c. Respite cannot exceed fourteen (14) consecutive days. (3-20-20)

d. Respite must not be provided at the same time other Medicaid services are being provided with the exception of when an unpaid caregiver is receiving family education. (3-20-20)

e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others and must be documented in the participant's record. (3-20-20)

f. When respite is provided as group respite, the following applies: (3-20-20)

i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio must be adjusted accordingly. (3-20-20)

ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio in the group must be adjusted accordingly. (3-13-20)T

g. Respite cannot be provided as center-based by an independent respite provider. An independent respite provider may only provide group respite when the following are met: (3-20-20)

i. The independent respite provider is a relative; and (3-13-20)T

ii. The service is delivered in the home of the participants or the independent respite provider. (3-20-20)

02. Community-Based Supports. Community-based supports provides assistance to a participant by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Community-based supports must: (3-20-20)

a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; (3-20-20)

b. Ensure the participant is involved in age-appropriate activities in environments typical peers access according to the ability of the participant; and (3-20-20)

c. Have a minimum of one (1) qualified staff providing direct services for up to six (6) participants when provided as group community-based supports. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff participant ratio must be adjusted accordingly. (3-13-20)T

03. Family Education. Family education is professional assistance to family members, or others, who participate in caring for the eligible participant to help them better meet the needs of the participant by providing an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to the participant’s diagnosis. It offers education that is specific to the needs of the family and participant as identified on the plan of service. (3-20-20)

a. Family education providers must maintain documentation of the training in the participant's record including the provision of activities outlined in the plan of service. (3-20-20)

04. Family-Directed Community Supports (FDCS). Families of participants eligible for the children's DD HCBS state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 523.01 through 523.04 of this rule when the participant lives at home with their parent or legal guardian. All services provided under FDCS option must be delivered on a one-to-one basis, must be identified on a plan of service developed by the family-centered planning team, and must be prior authorized. Additional requirements for this option are outlined in Sections 520 through 522, Subsections 523.05-06 524.01-03, 524.07-10, and 525.01, and Section 528, of these rules, and IDAPA 16.03.13, “Consumer-Directed Services.” (3-20-20)

05. Limitations. (3-20-20)

a. Children's DD HCBS state plan option services are limited by the participant's individualized budget amount. (3-20-20)

b. Services offered in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may not be authorized under these rules. (3-20-20)

c. Duplication of services cannot be provided. Services are considered duplicate when: (3-20-20)

i. An adaptive equipment and support service address the same goal; (3-20-20)

ii. Multiple adaptive equipment items address the same goal; (3-20-20)

iii. Goals are not separate and unique to each service provided; or (3-20-20)

iv. When more than one (1) service is provided at the same time, unless otherwise authorized. (3-20-20)

d. For the children's DD HCBS state plan option listed in Subsections 523.01, 523.02, and 523.03 of this rule, the following are excluded for Medicaid payment: (3-20-20)

i. Vocational services; (3-20-20)

ii. Educational services; and (3-20-20)

iii. Recreational services. (3-20-20)

06. HCBS Compliance. Providers of children's DD HCBS are responsible for ensuring that they meet the setting quality requirements described in Section 313 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. (3-20-20)

524. CHILDREN'S DD HCBS STATE PLAN OPTION: PLAN OF SERVICE PROCESS.
In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 522 of these rules and must identify all services. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. Paid plan development must be provided by the Department, or its contractor, in accordance with Section 316 of these rules. (3-20-20)

01. History and Physical. Prior to the development of the plan of service, the plan developer must obtain a current history and physical completed by a practitioner of the healing arts. For participants in Healthy Connections, the Healthy Connections physician may conduct the history and physical and refer the participant for other evaluations. (3-13-20)T

02. Plan of Service Development. The plan of service must be developed with the child participant, the participant's decision-making authority, and facilitated by the Department, or its designee. If the participant is unable to attend the family-centered planning meeting, the plan of service must contain documentation to justify the participant's absence. With the decision-making authority's consent, the family-centered planning team may include other family members or participants who are significant to the participant. (3-20-20)

03. Requirements for Collaboration. Providers of children's DD HCBS must coordinate with the family-centered planning team as specified on the plan of service. (3-20-20)

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months and document the plan monitor's name along with the monitoring frequency on the plan. The plan developer is considered the plan monitor and must meet face-to-face with the

participant and the participant's decision-making authority. Plan monitoring includes reviewing the plan of service with the participant and the participant's decision-making authority to identify the current status of services, any barriers to services, and any necessary changes to the plan of service. (3-13-20)T

05. Provider Status Reviews. The service providers identified in Section 526 of these rules must report the participant's progress toward goals to the plan monitor. The provider must complete a six (6) month and annual provider status review. (3-13-20)T

06. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan and these adjustments must be based on changes in a participant's need and requested by the parent or legal guardian. Adjustment of the plan of service requires the decision-making authority's signature and prior authorization by the Department. The Department will distribute the addendum to the providers involved in the addendum's implementation. Upon receipt by the provider, the addendum must be reviewed, signed, and returned to the Department, with a copy maintained in the participant's record. (3-20-20)

07. Reauthorization of Services. A participant's plan of service must be reauthorized. The Department must review and authorize the new plan of service. (3-13-20)T

08. Eligibility Determination Results. A determination must be completed in accordance with Section 522 of these rules. (3-13-20)T

09. Adjustments to the Annual Budget and Services. The annual budget may be adjusted when there are documented changes that may support placement in a different budget category as identified in Section 522 of these rules. Services may be adjusted at any time during the plan year. (3-20-20)

10. Reapplication After a Lapse in Service. For participants who are re-applying for service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-20-20)

525. CHILDREN'S DD HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. Requirements for Prior Authorization. Prior authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization is intended to help ensure the provision of necessary and appropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with rules for HCBS as described in Sections 310 through 313 and 316 and 317 of these rules, and for the specific services included on the plan. Delivery of each service identified on the plan of service cannot be initiated until the plan has been signed by the parent or participant's decision-making authority, the provider responsible for service provision, and has been authorized by the Department. (3-20-20)

02. Requirements for Supervision. All children’s DD HCBS provided by a DDA or independent provider must be supervised. The supervisor must meet the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Section 575, “Children's Habilitation Intervention Services.” The observation and review of the direct services must be performed by all staff to ensure staff demonstrate the necessary skills to correctly provide the services as defined in this rule set. (3-13-20)T

03. Requirements for Quality Assurance. Providers of DD HCBS state plan option must demonstrate high quality of services through an internal quality assurance review process. (3-20-20)

04. General Requirements for Program Documentation. The provider must maintain records for each participant served. Program documentation must be maintained by the independent provider or DDA in accordance with IDAPA 16.05.07, “Investigation and Enforcement of Fraud, Abuse, and Misconduct,” Section 101. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. For each participant, the following program documentation is required: (3-20-20)

a. Date and time of visit; (3-20-20)

b. Support services provided during the visit; (3-20-20)

c. A summary of session or services provided; (3-20-20)

d. Length of visit, including time in and time out; (3-20-20)

e. Location of service; and (3-20-20)

f. Signature of the individual providing the service and date signed. (3-20-20)

05. Community-Based Supports Documentation. In addition to the general requirements listed in Subsection 525.04 of this rule, the supervisor must complete at a minimum, six (6) month and annual provider status reviews for community-based support services provided. These provider status reviews must be completed more frequently when required on the plan of service and must: (3-20-20)

a. Be submitted to the plan monitor; and (3-20-20)

b. Be submitted on Department-approved forms. (3-20-20)

06. Family Education Documentation. In addition to the general requirements listed in Subsection 525.04 of this rule, the DDA or independent provider must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. (3-20-20)

526. CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES. All providers of children's DD HCBS state plan option must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-20-20)

01. Respite. Respite may be provided by an agency that is certified as a DDA or by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite must meet the following minimum qualifications: (3-20-20)

a. Be at least sixteen (16) years of age when employed by a DDA; or (3-20-20)

b. Be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an independent respite provider; and (3-20-20)

c. Have received instructions in the needs of the participant who will be provided the service; (3-20-20)

d. Demonstrate the ability to provide services according to a plan of service; (3-20-20)

e. Satisfactorily complete a criminal history background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks,"; and (3-13-20)T

f. When employed by a DDA, be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent respite providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. (3-20-20)

02. Community-Based Support. Community-based supports may be provided by a DDA or an independent provider. An independent provider is an individual who has entered into a provider agreement with the Department. Providers of community-based supports must meet the following minimum qualifications: (3-20-20)

a. Be at least eighteen (18) years of age; (3-20-20)

b. Have received instructions in the needs of the participant who will be provided the service; (3-20-20)

c. Demonstrate the ability to provide services according to a plan of service; (3-20-20)

d. Have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: (3-20-20)

i. Have previous work experience gained through paid employment, university practicum experience, or internship; or (3-20-20)

ii. Have on-the-job supervised experience gained through employment with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services. (3-13-20)T

iii. For individuals providing community-based supports to children birth to age three (3), the six (6) months of documented experience must be with infants, toddlers, or children birth to age three (3) years of age with developmental delays or disabilities. (3-20-20)

e. Complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide community-based supports. (3-20-20)

f. Satisfactorily complete a criminal history background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks,"; and (3-13-20)T

g. When employed by a DDA, be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. (3-20-20)

03. Family Education. Family Education can be provided by an agency certified as a DDA or an individual who holds an independent habilitation intervention provider agreement with the Department and meets the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits". (3-20-20)

527. CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis for services identified on the participant's plan of service and within the participant's individualized budget. The Department will monitor the budget setting methodology on an ongoing basis to ensure that participant needs are accurately reflected in the methodology. (3-20-20)

01. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-20-20)

02. Rates. The reimbursement rates calculated for children's HCBS 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 transportation. (3-20-20)

528. CHILDREN'S DD HCBS STATE PLAN OPTION: DEPARTMENT'S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES.
Quality assurance activities will include the observation of service delivery with participants, review of participant records, and complete satisfaction interviews. All providers of support services must grant the Department immediate access to all information required to review compliance with these rules. (3-20-20)

01. Quality Assurance. The Department will conduct quality assurance by collaborating with providers to complete audits and reviews to ensure compliance with the Department's rules and regulations. These findings may lead to quality improvement activities to enhance provider processes and outcomes for the child. If problems are identified that impact health and safety or are not resolved through quality improvement activities, implementation of a corrective action process may occur. (3-20-20)

02. Quality Improvement. Quality improvement consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement activities must include: (3-20-20)

a. Consultation; (3-20-20)

b. Technical assistance and recommendations; or (3-20-20)

c. Corrective Action. (3-20-20)

03. Corrective Action. Corrective action is a formal process used by the Department to address significant, ongoing, or unresolved deficient practice identified during the review process as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, and includes: (3-20-20)

a. Issuance of a corrective action plan; (3-20-20)

b. Referral to Medicaid Program Integrity Unit; or (3-20-20)

c. Action against a provider agreement. (3-20-20)

529. -- 579. (RESERVED)

580. INTERMEDIATE CARE FACILITIES FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF/ID).
The Department will pay for services in an ICF/ID. An ICF/ID is an intermediate care facility whose primary purpose is to provide habilitative services and maintain optimal health status for individuals with intellectually disabilities or persons with related conditions. (3-19-07)

581. ICF/ID: ELIGIBILITY.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Department has determined that the individual meets the criteria for ICF/ID services. Entitlement will be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (3-29-12)

582. ICF/ID: DETERMINATION OF ENTITLEMENT FOR MEDICAID PAYMENT.
Applications for Medicaid payment of an individual with an intellectual disability or related condition, in an ICF/ID will be through the Department. All required information necessary for a medical entitlement determination must be submitted to the Department before a determination and approval for payment is made. The effective date of Medicaid payment will be no earlier than the physician's signed and dated certification for ICF/ID level of care. (3-29-12)

583. ICF/ID: INFORMATION REQUIRED FOR DETERMINATION.
Required information includes a medical evaluation, an initial plan of care, social evaluation, psychological evaluation, and initial plan of care by ICF/ID. (3-19-07)

01. Medical Evaluation. A complete medical evaluation, current within ninety (90) days of admission, signed and dated by the physician, an electronic physician's signature is permissible, that includes: (3-19-07)

a. Diagnosis (primary and secondary); (3-19-07)

b. Medical findings and history; (3-19-07)

c. Mental and physical functional capacity; (3-19-07)

d. Prognosis; mobility status; and (3-19-07)

e. A statement by the physician certifying the level of care needed as ICF/ID for a specific participant. (3-19-07)

02. Initial Plan of Care by Physicians. An initial plan of care, current within ninety (90) days of admission and signed and dated by the physician that includes: (3-19-07)

a. Orders for medications and treatments; (3-19-07)

b. Diet; and (3-19-07)

c. Professional rehabilitative and restorative services and special procedures, where appropriate. (3-19-07)

03. Social Evaluation. A social evaluation, current within ninety (90) days of admission, that includes : (3-19-07)

a. Condition at birth; (3-19-07)

b. Age at onset of condition; (3-19-07)

c. Summary of functional status, such as skills level, activities of daily living; and (3-19-07)

d. Family social information. (3-19-07)

04. Psychological Evaluation. A psychological evaluation conducted by a psychologist current within ninety (90) days of admission, that includes: (3-19-07)

a. Diagnosis; (3-19-07)

b. Summary of developmental findings. Instead of a psychological, infants under three (3) years of age may be evaluated by a developmental disability specialist utilizing the developmental milestones congruent with the age of the infant; (3-19-07)

c. Mental and physical functioning capacity; and (3-19-07)

d. Recommendation concerning placement and primary need for active treatment. (3-19-07)

05. Initial Plan of Care by ICF/ID. An initial plan of care developed by the admitting ICF/ID. (3-19-07)

584. ICF/ID: CRITERIA FOR DETERMINING ELIGIBILITY.
Individuals who have intellectual disabilities or a related condition as defined in Section 66-402, Idaho Code, and Sections 500 through 503 of these rules, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/ID or receive services under one of Idaho's programs to assist individuals with intellectual disabilities or a related condition to avoid institutionalization in an ICF/ID, as indicated in Section 584.02 of these rules. To meet Title XIX and Title XXI entitlement for ICF/ID level of care and be eligible for services provided in an ICF/ID. The following must be met in Subsections 584.01 through 584.08 of these rules. (3-19-07)

01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. (3-19-07)

02. Active Treatment. Persons living in an ICF/ID, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain their functional level. (3-19-07)

a. Active treatment does not include: parenting activities directed toward the acquisition of age-appropriate developmental milestones; services to maintain generally independent individuals who are able to

function with little supervision or in the absence of a continuous active treatment program or services; interventions that address age-appropriate limitations; or general supervision of children whose age is such that such supervision is required by all children of the same age. (3-19-07)

b. The following criteria/components will be utilized when evaluating the need for active treatment: (3-19-07)

i. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the participant and the interventions needed; and (3-19-07)

ii. Plan of Care. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. (3-19-07)

03. Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future. (3-19-07)

04. Care for a Child. The department may provide Medicaid to a child eighteen (18) years of age or younger, who would be eligible for Medicaid if they were in a medical institution and who are receiving, while living at home, medical care that would be provided in a medical institution, if the Department determines that the child requires the level of care provided in an ICF/ID. (3-19-07)

05. Functional Limitations. (3-19-07)

a. Persons Sixteen Years of Age or Older. Persons sixteen (16) years of age or older may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment using a Department-approved assessment tool would qualify; or (7-1-18)

b. Persons Under Sixteen Years of Age. Persons under sixteen (16) years of age qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or(7-1-18)

06. Maladaptive Behavior. (3-19-07)

a. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on a Department-approved assessment tool is minus twenty-two (-22) or less; or (7-1-18)

b. Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or (3-19-07)

07. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 584.05 and 584.06 of these rules at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (3-19-07)

a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on a Department-approved assessment tool up to minus seventeen (-17), minus twenty-two (-22) inclusive; or (7-1-18)

b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on a Department-approved assessment tool between minus seventeen (-17), and minus

twenty-one (-21) inclusive; or (7-1-18)

08. Medical Condition. Individuals may meet ICF/ID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services. (3-19-07)

09. Annual Redetermination for ICF/ID Level of Care for Community Services. The BLTC staff will redetermine the participant's continuing need for ICF/ID level of care for community services. Documentation will consist of the completion of a redetermination statement on the "Level of Care" form HW0083. Such documentation will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination. (3-20-20)

a. Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/ID eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. (3-19-07)

b. Developmentally Disabled Waiver. Individuals receiving developmentally disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. (3-19-07)

585. ICF/ID: COVERAGE REQUIREMENTS AND LIMITATIONS.
The minimum content of care and services for ICF/ID must include the services listed below and social and recreational activities. (3-19-07)

01. Care and Services Provided. (3-19-07)

a. The minimum content of care and services for ICF/ID participants must include the following: (3-19-07)

i. Room and board; and (3-19-07)

ii. Bed and bathroom linens; and (3-19-07)

iii. Nursing care, including special feeding if needed; and (3-19-07)

iv. Personal services; and (3-19-07)

v. Supervision as required by the nature of the participant's illness; and (3-19-07)

vi. Special diets as prescribed by a participant's physician; and (3-19-07)

vii. All common medicine chest supplies that do not require a physician's prescription including mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; and (3-20-20)

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

ix. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; and (3-19-07)

x. Application or administration of all drugs; and (3-19-07)

xi. All medical supplies including gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton or any other type of pads used to save labor or linen, and disposable gloves; and (3-20-20)

xii. Social and recreational activities; and (3-19-07)

xiii. Items that are utilized by individual participants but that are reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. (3-19-07)

02. Wheelchairs. DHW authorized purchases of specialized wheelchair and seating systems, and any authorized repairs related to the seating system, that are paid to a medical vendor directly by DHW will not be included in the content of care of ICFs/ID. The specialized wheelchairs and seating systems must be designed to fit the needs of a specific ICF/ID resident and cannot be altered to fit another participant cost effectively. (3-19-07)

586. ICF/ID: PROCEDURAL RESPONSIBILITIES.
Each long term care facility administrator, or their authorized representative, must report to the appropriate Field Office within three (3) working days of the date the facility has knowledge of the following. (3-19-07)

01. Readmissions or Discharges. Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. (3-19-07)

02. Changes to Participant's Income. Any changes in the amount of a participant's income. (3-19-07)

03. Participant's Account Exceeds Limitations. When a participant's account has exceed the following amount; (3-19-07)

a. For a single individual, one thousand eight hundred dollars ($1,800);or (3-19-07)

b. For a married couple, two thousand eight hundred dollars ($2,800). (3-19-07)

04. Other Financial Information for Participant. Other information about a participant's finances that may potentially affect eligibility for medical assistance. (3-19-07)

05. Annual Recertification Requirement. It is the responsibility of the ICF/ID to assure that the recertification is accomplished by the physician, physician's assistant or nurse practitioner no later than every three hundred sixty-five (365) days. (3-19-07)

a. Should the Medicaid Program receive a financial penalty from the Department of Health and Human Services due to the lack of appropriate recertification on the part of an ICF/ID, then such amount of money will be withheld from facility payments for services provided to Medicaid participants. For audit purposes, such financial losses are not reimbursable as a reasonable cost of participant care. Such losses cannot be made the financial responsibility of the Department's participant. (3-19-07)

b. Persons living in an ICF/ID will be transitioned to a less restrictive environment within thirty (30) days of the determination that the participant does not meet ICF/ID level of care. (3-19-07)

06. Level of Care Change. If during an on-site review of a resident's medical record and an interview with or observation of the resident an IOC/UC reviewer determines there is a change in the resident's status and the resident no longer meets criteria for ICF/ID care, the tentative decision is: (3-19-07)

a. Discussed with the facility administrator or the director of nursing services; (3-19-07)

b. The resident's physician is notified of the tentative decision; (3-19-07)

c. The case is submitted to the Regional Review Committee for a final decision; and (3-19-07)

d. The effective date of loss of payment will be no earlier than ten (10) days following the date of mailing of notice to the participant by the Eligibility Examiner. (3-19-07)

07. Appeal of Determinations. The resident or their representative may appeal the decisions under IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings.” (3-19-07)

08. Supplemental On-Site Visit. The Regional Nurse Reviewer may conduct utilization control supplemental on-site visits in an ICF/ID when indicated. Some indications may be: (3-19-07)

a. Follow-up activities; (3-19-07)

b. A verification of a participant's appropriateness of placement or services; and (3-19-07)

c. Conduct complaint investigations at the Department's request. (3-19-07)

09. Determination of Entitlement to Long-Term Care. Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Regional Nurse Reviewer has determined that the individual meets the criteria for ICF/ID care and services. Entitlement will be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. (3-19-07)

a. The criteria for determining a Participant's need for intermediate care for the intellectually disabled is described in Sections 583 and 584 of these rules. In addition, the IOC/UC nurse must determine whether a Participant's needs could be met by non-participant inpatient alternatives including remaining in an independent living arrangement or residing in a room and board situation. (3-19-07)

b. The participant can select any certified facility to provide the care required. (3-19-07)

c. The final decision as to the level of care required by a participant must be made by the IOC/UC Nurse. (3-19-07)

d. The final decision as to the need for DD or MI active treatment will be made by the appropriate Department staff as a result of the Level II screening process. (3-19-07)

e. No payment will be made by the Department on behalf of any eligible participant to any long-term care facility that, in the judgment of the Inspection Of Care/Utilization Control Team is admitting individuals for care or services that are beyond the facility's licensed level of care or capability. (3-19-07)

10. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field Office will forward to such facility an “Authorization for Long-Term Care Payment” form HW 0459. (3-19-07)

587. ICF/ID: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as an ICF/ID facility. (3-19-07)

02. Licensure and Certification. (3-19-07)

a. Upon receipt of an application from a facility, the Licensing and Certification Agency will conduct a survey to determine the facility's compliance with certification standards for the type of care the facility proposes to provide to participants. (3-19-07)

b. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for ICF/ID, the Department will certify to the appropriate branch of government that the facility meets the standards for ICF/ID types of care. (3-19-07)

c. Upon receipt of the certification from the Licensing and Certification Agency, the Bureau may enter into a provider agreement with the long-term care facility. (3-19-07)

d. After the provider agreement has been executed by the Facility Administrator and by the bureau

chief, one (1) copy will be sent by certified mail to the facility and the original is to be retained by the Bureau. (3-20-20)

03. Direct Care Staff. Direct Care staff in an ICF/ID are defined as the present on-duty staff calculated over all shifts in a twenty-four (24) hour period for each defined residential living unit. Direct care staff in an ICF/ID include those employees whose primary duties include the provision of hands-on, face-to-face contact with the participants of the facility. This includes both regular and live-in/sleep-over staff. It excludes professionals such as psychologists, nurses, and others whose primary job duties are not the provision of direct care, as well as managers/supervisors who are responsible for the supervision of staff. (3-19-07)

04. Direct Care Staffing Levels. The reasonable level of direct care staffing provided to a participant in an ICF/ID setting will be dependent upon the level of involvement and the need for services and supports of the participant as determined by the Department. Level of involvement relates to the severity of a participant's intellectual disability. Those levels, in decreasing level of severity, are: profound, severe, moderate, and mild. Staffing levels will be subject to the following constraints: (3-19-07)

a. Direct care staffing for a severely and profoundly intellectually disabled participant residing in an ICF/ID must be a maximum of sixty-eight point twenty five (68.25) hours per week. (3-19-07)

b. Direct care staffing for a moderately intellectually disabled participant residing in an ICF/ID must be limited to a maximum of fifty-four point six (54.6) hours per week. (3-19-07)

c. Direct care staffing for a mildly intellectually disabled participant residing in an ICF/ID must be limited to a maximum of thirty four point one two five (34.125) hours per week. (3-19-07)

05. Direct Care Staff Hours. The annual sum total level of allowable direct care staff hours for each residential living unit will be determined in the aggregate as the sum total of the level of staffing allowable for each resident residing in that residential living unit as determined in Subsection 587.04 of these rules. (3-19-07)

06. Phase-In Period. If enactment of Subsection 587.04 of these rules requires a facility to reduce its level of direct care staffing, a six (6) month phase-in period will be allowed from the date of the enactment of this section, without any resulting disallowances. Should disallowances result, the hourly rate of direct care staff used in determining disallowances will be the weighted average of the hourly rates paid to a facility's direct care staff, plus the associated benefits, at the end of the phase-in period. (3-19-07)

07. Exceptions. Should a provider be able to show convincing evidence documenting that the annual aggregate direct care hours as allowed under this section will compromise their ability to supply adequate care to the participants, as required by federal regulations and state rules, within an ICF/ID residential living unit and that other less costly options would not alleviate the situation, the Department will approve an additional amount of direct care hours sufficient to meet the extraordinary needs. This adjustment will only be available up through September 30, 1996. (3-19-07)

588. ICF/ID: PROVIDER REIMBURSEMENT.

01. Payment Methodology. ICF/ID facilities will be reimbursed in accordance with the methodology listed in Sections 588 through 633 of these rules. (3-19-07)

02. Date of Discharge. Payment by the Department for the cost of ICF/ID care is to include the date of the participant's discharge only if the discharge occurred after 3 p.m. and is not discharged to a related provider. If a Medicaid patient dies in an ICF/ID, their date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. (3-19-07)

589. ICF/ID: REASONABLE COST PRINCIPLES.

To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to beneficiaries will result. (3-19-07)

01. Application of Reasonable Cost Principles. (3-19-07)

a. Reasonable costs of any services are determined in accordance with rules found in the Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. (3-19-07)

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. (3-19-07)

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. (3-19-07)

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Chapter 1, Idaho Code, or are unallowable by application of promulgated regulation. (3-19-07)

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (3-19-07)

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. (3-19-07)

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. (3-20-20)

03. Costs Not Related to Patient Care. Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. (3-20-20)

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. (3-20-20)

590. ICF/ID: ALLOWABLE COSTS.
The following definitions and explanations apply to allowable costs: (3-19-07)

01. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable. (3-19-07)

02. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement cannot exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee. (3-19-07)

03. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable as provided in PRM, Section 300. (3-19-07)

04. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. (3-19-07)

05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section 597 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: (3-19-07)

a. Salaries wages, bonuses and benefits that are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. (3-19-07)

b. Supplies and services provided for the owner's personal use. (3-19-07)

c. Compensation paid by the facility to employees for the sole benefit of the owner. (3-19-07)

d. Fees for consultants, directors, or any other fees paid regardless of the label. (3-19-07)

e. Keyman life insurance. (3-19-07)

f. Living expenses, including those paid for related persons. (3-19-07)

06. Contracted Service. All services that are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. (3-19-07)

07. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Section 630 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. (3-19-07)

08. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met. (3-19-07)

09. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. (3-19-07)

10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable. (3-19-07)

11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment. (3-19-07)

12. Food. Costs of raw food are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food. (3-20-20)

13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers. (3-19-07)

14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are

allowable to the extent that they are related to patient care. (3-19-07)

15. **Interest**. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. (3-19-07)

16. **Lease or Rental Payments**. Payments for the property cost of the lease or rental of land, buildings, and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/ID day treatment services will not be reported as property costs and will be allowable based on reasonable cost principles subject to other limitations contained herein. (3-19-07)

17. **Malpractice or Public Liability Insurance**. Premiums for malpractice and public liability insurance must be reported as administrative costs. (3-19-07)

18. **Payroll Taxes**. The employer's portion of payroll taxes is reimbursable. (3-19-07)

19. **Property Costs**. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For ICFs/ID, the property rental rate is paid as described in Section 630 of these rules. (3-19-07)

a. Amortization of leasehold improvements will be included in property costs. (3-19-07)

i. Straight line depreciation on fixed assets is included in property costs. (3-19-07)

ii. Depreciation of moveable equipment is an allowable property cost. (3-19-07)

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities. (3-19-07)

20. **Property Insurance**. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. (3-19-07)

21. **Repairs and Maintenance**. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. (3-19-07)

22. **Salaries**. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost. (3-19-07)

23. **Supplies**. Cost of supplies used in patient care or providing services related to patient care is allowable. (3-19-07)

24. **Taxes**. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs. (3-19-07)

591. ICF/ID: NONALLOWABLE COSTS.
The following definitions and explanations apply to nonallowable costs: (3-19-07)

01. **Accelerated Depreciation**. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable. (3-19-07)

02. **Acquisitions**. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable. (3-19-07)

03. **Charity Allowances**. Cost of free care or discounted services are nonallowable. (3-19-07)

04. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility are nonallowable. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This subsection in no way limits the Department's ability to disallow excessive consultant costs under other sections of this chapter, such as Section 589 or 595 of these rules, when applicable. (3-19-07)

05. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1. (3-19-07)

06. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2. (3-19-07)

07. Goodwill. Costs associated with goodwill as defined in Section 011 of these rules are nonallowable. (3-19-07)

08. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A. (3-19-07)

09. Interest. Interest to finance nonallowable costs are nonallowable. (3-19-07)

10. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. (3-19-07)

11. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable. (3-19-07)

12. Organization. Organization costs are nonallowable, see PRM, Section 2134. (3-19-07)

13. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable. (3-19-07)

14. Prescription Drugs. Prescription drug costs are nonallowable. (3-19-07)

15. Related Party Interest. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2. (3-19-07)

16. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated. (3-19-07)

17. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. (3-19-07)

18. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, that apply to facility owners are nonallowable. (3-19-07)

19. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. (3-19-07)

20. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs. (3-19-07)

592. ICF/ID: HOME OFFICE COST PRINCIPLES.
The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the

home office, through the provider, will provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. (3-19-07)

593. ICF/ID: RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. (3-19-07)

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. (3-19-07)

594. ICF/ID: APPLICATION OF RELATED PARTY TRANSACTIONS.

01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. (3-19-07)

a. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. (3-19-07)

b. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control that is decisive, not its form or the mode of its exercise. (3-19-07)

02. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. (3-19-07)

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the program. (3-19-07)

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics. (3-19-07)

595. ICF/ID: COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. (3-19-07)

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. (3-19-07)

a. Where such persons perform services without pay, no cost may be imputed. (3-19-07)

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. (3-19-07)

c. Compensation for undocumented hours worked will not be a reimbursable cost. (3-19-07)

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: (3-19-07)

a. Husband or wife; (3-19-07)

b. Son or daughter or a descendant of either; (3-19-07)

c. Brother, sister, stepbrother, stepsister or descendant thereof; (3-19-07)

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; (3-19-07)

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; (3-19-07)

f. A descendant of a brother or sister of the provider's father or mother; (3-19-07)

g. Any other person with whom the provider does not have an arms length relationship. (3-19-07)

596. ICF/ID: INTEREST EXPENSE.
Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. (3-19-07)

597. ICF/ID: IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this section. (3-19-07)

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 2002.

Licensed Bed Range	Upper limit
51 - 100	86,951
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

(3-19-07)

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm. (3-19-07)

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 597.01. of these rules. Allowable compensation will be determined as follows: (3-19-07)

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility. (3-19-07)

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. (3-19-07)

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an

owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 597.01 of these rules. (3-19-07)

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. (3-19-07)

05. When an Owner Provides Services to More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. (3-19-07)

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). (3-19-07)

598. -- 599. (RESERVED)

600. ICF/ID: OCCUPANCY ADJUSTMENT FACTOR.
In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: (3-19-07)

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section 013 of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. (3-19-07)

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. (3-19-07)

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. (3-19-07)

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. (3-19-07)

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. (3-19-07)

601. ICF/ID: RECAPTURE OF DEPRECIATION.
Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility

subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. (3-19-07)

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. (3-19-07)

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. (3-19-07)

602. ICF/ID: REPORTING SYSTEM.
The objective of the reporting requirements is to provide a uniform system of periodic reports that will allow: (3-19-07)

01. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs. (3-19-07)

02. Disclosure. Adequate financial disclosure. (3-19-07)

03. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. (3-19-07)

04. Criteria. Criteria for evaluating policies and procedures. (3-19-07)

603. ICF/ID: REPORTING SYSTEM PRINCIPLE AND APPLICATION.
The provider will be required to file mandatory annual cost reports. (3-19-07)

01. Cost Report Requirements. The fiscal year end cost report filing must include: (3-19-07)

a. Annual income statement (two (2) copies); (3-19-07)

b. Balance sheet; (3-19-07)

c. Statement of ownership; (3-19-07)

d. Schedule of patient days; (3-19-07)

e. Schedule of private patient charges; (3-19-07)

f. Statement of additional charges to residents over and above usual monthly rate; and (3-19-07)

g. Other schedules, statements, and documents as requested. (3-19-07)

02. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance. (3-19-07)

03. Criteria of Reports. All reports must meet the following criteria: (3-19-07)

a. State-approved formats are used. (3-19-07)

b. Presented on accrual basis. (3-19-07)

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. (3-19-07)

d. Appropriate detail is provided on supporting schedules or as requested. (3-19-07)

04. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. (3-19-07)

05. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. (3-19-07)

06. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements will be met: (3-19-07)

a. Outgoing management or administration will file an adjusted-period cost report if it is necessary. This report will meet the criteria for annual cost reports, except that it will be filed not later than sixty (60) days after the change in management or ownership. (3-19-07)

b. The Department may require an appraisal at the time of a change in ownership. (3-19-07)

07. Reporting Period. When required for establishing rates, new ICF/ID providers will be required to submit cost projections for the first year of operations. Thereafter, the normal reporting period coincides with the provider's standard fiscal year. If a provider withdraws from the program and subsequently re-enters, the new provider reporting requirements will apply. (3-19-07)

604. (RESERVED)

605. ICF/ID: FILING DATES.

01. Deadlines. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. (3-19-07)

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. (3-19-07)

606. ICF/ID: FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. (3-19-07)

607. ICF/ID: ACCOUNTING SYSTEM.
Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. (3-19-07)

608. -- 609. (RESERVED)

610. ICF/ID: AUDITS.
All financial reports are subject to audit by Departmental representatives. (3-19-07)

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. (3-19-07)

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. (3-19-07)

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the required care on the a basis of economy and efficiency. (3-19-07)

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. (3-19-07)

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding their fiduciary responsibilities for patients, funds and property. (3-19-07)

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. (3-19-07)

07. Compliance. To provide recommendations that will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program participants. (3-19-07)

08. Final Settlement. To effect final settlement when required by Sections 587 through 632 of these rules. (3-19-07)

611. ICF/ID: AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. (3-19-07)

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. (3-19-07)

03. Additional Audits. In addition, audits may be required where: (3-19-07)

a. A significant change of ownership occurs. (3-19-07)

b. A change of management occurs. (3-19-07)

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. (3-19-07)

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. (3-19-07)

612. ICF/ID: AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. (3-19-07)

02. Requirements. Providers Reimbursement Manual (PRM), Section 2404.3 states: “Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. (3-19-07)

03. Examination of Records. Examination of records and documents may include: (3-19-07)

a. Corporate charters or other documents of ownership including those of a parent or related companies. (3-19-07)

b. Minutes and memos of the governing body including committees and its agents. (3-19-07)

c. All contracts. (3-19-07)

d. Tax returns and records, including workpapers and other supporting documentation. (3-19-07)

e. All insurance contracts and policies including riders and attachments. (3-19-07)

f. Leases. (3-19-07)

g. Fixed asset records (see audit section - Capitalization of Assets). (3-19-07)

h. Schedules of patient charges. (3-19-07)

i. Notes, bonds and other evidences of liability. (3-19-07)

j. Capital expenditure records. (3-19-07)

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. (3-19-07)

l. Evidence of litigations the facility and its owners are involved in. (3-19-07)

m. Documents of ownership including attachments that describe the property. (3-19-07)

n. All invoices, statements and claims. (3-19-07)

o. Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, paragraph 2404.4(Q). (3-19-07)

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. (3-19-07)

q. All patient records, including trust funds and property. (3-19-07)

r. Time studies and other cost determining information. (3-19-07)

s. All other sources of information needed to form an audit opinion. (3-19-07)

04. Adequate Documentation. (3-19-07)

a. Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to participants. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation that pertains to the determination of reasonable cost, capable of being audited under PRM, Section 2304. (3-19-07)

b. Adequate expenses documentation including an invoice, or a statement with invoices attached that support the statement. All invoices should meet the following standards: (3-19-07)

i. Date of service or sale; (3-19-07)

ii. Terms and discounts; (3-19-07)

iii. Quantity; (3-19-07)

iv. Price; (3-19-07)

v. Vendor name and address; (3-19-07)

vi. Delivery address if applicable; (3-19-07)

vii. Contract or agreement references; and (3-19-07)

viii. Description, including quantity, sizes, specifications brand name, services performed. (3-19-07)

c. Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (3-19-07)

d. Completed depreciation records must meet the following criteria for each asset: (3-19-07)

i. Description of the asset including serial number, make, model, accessories, and location. (3-19-07)

ii. Cost basis should be supported by invoices for purchase, installation, etc. (3-19-07)

iii. Estimated useful life. (3-19-07)

iv. Depreciation method such as straight line, double declining balance, etc. (3-19-07)

v. Salvage value. (3-19-07)

vi. Method of recording depreciation on a basis consistent with accounting policies. (3-19-07)

vii. Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. (3-19-07)

viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. (3-19-07)

e. Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (3-19-07)

f. The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 2004 revised edition. Guidelines Lives, that is hereby incorporated by reference into these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-19-07)

g. Lease purchase agreements may generally be recognized by the following characteristics: (3-19-07)

i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; (3-19-07)

ii. Intent to create security interest; (3-19-07)

iii. Lessee may acquire title through exercise of purchase option that requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; (3-19-07)

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and (3-19-07)

v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. (3-19-07)

h. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. (3-19-07)

i. Complete personnel records containing the following: (3-19-07)

i. Application for employment. (3-19-07)

ii. W-4 Form. (3-19-07)

iii. Authorization for other deductions such as insurance, credit union, etc. (3-19-07)

iv. Routine evaluations. (3-19-07)

v. Pay raise authorization. (3-19-07)

vi. Statement of understanding of policies, procedures, etc. (3-19-07)

vii. Fidelity bond application (where applicable). (3-19-07)

05. Internal Control. (3-19-07)

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: (3-19-07)

i. Safeguarding assets and resources against waste, fraud, and inefficiency. (3-19-07)

ii. Promoting accuracy and reliability in financial records. (3-19-07)

iii. Encouraging and measuring compliance with company policy and legal requirements. (3-19-07)

iv. Determining the degree of efficiency related to various aspects of operations. (3-19-07)

b. An adequate system of internal control over cash disbursements would normally include: (3-19-07)

i. Payment on invoices only, or statements supported by invoices. (3-19-07)

ii. Authorization for purchase such as a purchase order. (3-19-07)

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (3-19-07)

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (3-19-07)

v. Check of invoice accuracy. (3-19-07)

vi. Approval policy for invoices. (3-19-07)

vii. Method of invoice cancellation to prevent duplicating payment. (3-19-07)

viii. Adequate separation of duties between ordering, recording, and paying. (3-19-07)

ix. System separation of duties between ordering, recording, and paying. (3-19-07)

x. Signature policy. (3-19-07)

xi. Pre-numbered checks. (3-19-07)

xii. Statement of policy regarding cash or check expenditures. (3-19-07)

xiii. Adequate internal control over the recording of transactions in the books of record. (3-19-07)

xiv. An imprest system for petty cash. (3-19-07)

06. Accounting Practices. Sound accounting practices normally include the following: (3-19-07)

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. (3-19-07)

b. Chart of accounts. (3-19-07)

c. A budget or operating plan. (3-19-07)

613. ICF/ID: PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. (3-19-07)

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. (3-19-07)

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: (3-19-07)

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. (3-19-07)

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or their agent in writing. (3-19-07)

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. (3-19-07)

03. Fund Management. Proper management of such funds would include the following as minimum: (3-19-07)

a. Savings accounts, maintained separately from facility funds. (3-19-07)

b. An accurate system of supporting receipts and disbursements to patients. (3-19-07)

c. Written authorization for all deductions. (3-19-07)

d. Signature verification. (3-19-07)

e. Deposit of all receipts of the same day as received. (3-19-07)

f. Minimal funds kept in the facility. (3-19-07)

g. As a minimum these funds must be kept locked at all times. (3-19-07)

h. Statement of policy regarding patient's funds and property. (3-19-07)

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. (3-19-07)

j. System of periodic review and correction of policies and financial records of patient property and funds. (3-19-07)

614. (RESERVED)

615. ICF/ID: POST-ELIGIBILITY TREATMENT OF INCOME.

01. Treatment of Income. Where an individual is determined eligible for medical assistance participation in the cost of their long term care, the Department will reduce its payment to the long term care facility by the amount of their income considered available to meet the cost of his care. This determination is made in accordance IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Sections 721 through 725. (3-19-07)

02. SSA Income. The amount that the Participant receives from SSA as reimbursement for their payment of the premium for Part B of Title XVIII (Medicare) is not considered income for participant liability in accordance with IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)." (3-19-07)

616. -- 619. (RESERVED)

620. ICF/ID: PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE.
Payments may be made for reserving beds in ICFs/ID for participants during their temporary absence if the facility charges private paying participants for reserve bed days, subject to the following limitations: (3-19-07)

01. Prior Approval for Absence. Therapeutic home visits for ICF/ID residents of up to thirty-six (36) days per calendar year so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the BLTC must be obtained for any home visits exceeding fourteen (14) consecutive days. (3-20-20)

02. Limits on Amount of Payments. Payment for reserve bed days will be lesser of the following: (3-19-07)

a. One hundred percent (100%) of the audited allowable costs of the facility; or (3-19-07)

b. The rate charged to private paying participants for reserve bed days. (3-19-07)

621. ICF/ID: PAYMENT PROCEDURES.
Each ICF/ID must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim in behalf of a Participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. (3-19-07)

622. ICF/ID: PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/ID facilities will be paid a per diem rate that, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider must report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/ID providers. Total payment will include the following components: Property reimbursement, capped costs, exempt costs, and excluded costs. Except as otherwise provided in this section, rates calculated for state fiscal year 2012 (July 1, 2011 through June 30, 2012) will be calculated by using finalized cost reports ended in calendar year 2009 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2011, through June 30, 2012. Rates effective July 1, 2012, and every July 1 thereafter, will be calculated by using audited cost reports ended in the calendar year two (2)

years prior to each July 1 (July 1, 2012, rates will use cost reports ended in calendar year 2010 and so forth), with no cost or cost limit adjustments for inflation. (4-4-13)

623. ICF/ID: PROPERTY REIMBURSEMENT.
Beginning October 1, 1996, ICF/ID property costs are reimbursed by a rental rate or based on cost. The following will be reimbursed based on cost as determined by the provisions of this chapter and applicable provisions of PRM to the extent not inconsistent with this chapter: ICF/ID living unit property taxes, ICF/ID living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and will not be reported in the property cost portion of the cost report. These costs will be reported in the home office and day treatment section of the cost report. Property costs, including costs that are reimbursed based on a rental rate, will be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs that are identified as an integral part of an appraisal. Property costs include the following components: (3-19-07)

01. Depreciation. Allowable depreciation based on straight line depreciation. (3-19-07)

02. Interest. All allowable interest expense that relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap. (3-19-07)

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs. (3-19-07)

04. Lease Payments. All allowable lease or rental payments. (3-19-07)

05. Property Taxes. All allowable property taxes. (3-19-07)

06. Costs of Related Party Leases. Costs of related party leases are to be reported in the property cost categories based on the owner's costs. (3-19-07)

624. ICF/ID: CAPPED COST.
Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 623 of these rules and exempt costs or excluded costs in Section 627 or 628 of these rules. This Section defines items and procedures to be followed in determining allowable and exempt costs and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/ID cap. (3-19-07)

01. Costs Subject to the Cap. Items subject to the cap include all allowable costs except property costs identified in Section 623 of these rules and exempt costs or excluded costs identified in Section 627 or 628 of these rules. Property costs related to a home office are administrative costs, will not be reported as property costs, and are subject to the cap. (3-19-07)

02. Per Diem Costs. Costs to be included in this category will be divided by the total participant days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for both the purposes of determining the ICF/ID cap and of computing final reimbursement. (3-19-07)

03. Cost Data to Determine the Cap. Cost data to be used to determine the cap for ICF/ID facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. (3-19-07)

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free standing facilities. (3-19-07)

a. The projection method used in Section 624 of these rules to set the cap will also be used to set non property portions of the prospective rate that are not subject to the cap. (3-19-07)

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. (3-19-07)

05. Costs That Can be Paid Directly by the Department to Non ICF/ID Providers. Costs that can be paid directly by the Department to non ICF/ID providers are excluded from the ICF/ID prospective rates and ICF/ID cap: (3-19-07)

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. (3-19-07)

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. Items such as eyeglasses and hearing aids are covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." The cost of these services is not included as a part of ICF/ID costs. Reimbursement can be made to a professional providing these services through their billing the Medicaid Program on their own provider number. (4-11-19)

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using their own provider number. (3-19-07)

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: (3-19-07)

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. (3-19-07)

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 624.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. (3-19-07)

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 624.06.b. of these rules from the beginning to the midpoint of the Target Period. (3-19-07)

07. Cost Ranking. Prior to October 1st of each year the Director will determine the that percent above the median that will assure aggregate payments to ICF/ID providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30th of each year. Projected per diem costs as determined in this section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. (3-19-07)

a. The median of the range will be computed based on the available data points being considered as the total population of data points. (3-19-07)

b. The cap for each ICF/ID facility with a fiscal year beginning October 1, 1996, will be computed

prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30th, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. (3-19-07)

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 626 of these rules apply. (3-19-07)

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. (3-19-07)

e. A new cap and rate will be set on an annual basis for each facility the first of July every year. (3-19-07)

f. The cap and prospective rate will be determined and set on an annual basis for each facility July first of every year and will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. (3-19-07)

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 628 of these rules apply. (3-19-07)

h. A facility that commences to offer participant care services as an ICF/ID on or after October 1, 1996, will be subject to retrospective settlement until the first prospective rate is set. Such facility will be subject to the ICF/ID cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. (3-19-07)

625. (RESERVED)

626. ICF/ID: RETROSPECTIVE SETTLEMENT.
When retrospective settlement is applicable, it is based on allowable reimbursement in accordance with this chapter and based on an audit report. Retrospective settlement will be subject to the same caps and limits determined for prospective payments. (3-19-07)

01. A Provider's Failure to Meet Any of the Conditions. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits. (3-19-07)

02. A First Time Provider. A first time provider operating a new ICF/ID living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set in accordance with Sections 603, 605, and 606 of these rules and this chapter. A budget based on the best available information is required prior to opening for participant care so an interim rate can be set. (3-19-07)

03. New ICF/ID Living Unit. A new ICF/ID living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the non-property rate components based on similar components of rates most recently paid for the participants moving into the facility. The property rental rate will be set according to applicable provisions of this chapter. (3-19-07)

04. Change of Ownership of Existing ICF/ID Living Unit. Where there is a change of ownership of an existing ICF/ID living unit, the provider operating the ICF/ID living unit will not receive an adjustment of the

provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply. (3-19-07)

05. Fraudulent or False Claims. Providers who have made fraudulent or false claims are subject to retrospective settlement as determined by the Department. (3-19-07)

06. Excluded Costs. Excluded costs may be retrospectively settled according to the provisions of Section 247 of these rules. (3-19-07)

627. ICF/ID: EXEMPT COSTS.
Exempt costs are not subject to the ICF/ID cap. (3-19-07)

01. Day Treatment Services. As specified in this Section, the cost of day treatment services may be reimbursed in this category and may not be subject to the ICF/ID cap. (3-19-07)

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection. (3-19-07)

b. When a school or another agency or entity is responsible for or pays for services provided to a participant regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services that are paid for or should be paid for by an other agency. (3-19-07)

c. When ICF/ID day treatment services are performed for participants in a licensed Developmental Disability Center, the allowable cost of such services will be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/ID in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and will be reported as non-reimbursable. (3-19-07)

d. For day treatment services provided in a location other than a certified developmental disability center, the maximum amount reportable in this category will also be limited. Total costs for such services reported by each provider in this category will be limited to the number of hours, up to thirty (30) hours per week per participant, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection will be classified and reported as subject to the ICF/ID cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates will be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers. (3-19-07)

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services, must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, will be separately identified, will be reported as day treatment services costs, and will not include property costs otherwise reimbursed. Property costs related to day treatment services will be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or will be separate and distinct from any property used for ICF/ID services that are or were day treatment services. (3-19-07)

f. In the event a provider has a change in the number of participants requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that

further changes can be identified and the prospective rate adjusted accordingly. (3-19-07)

02. Major Movable Equipment. Costs related to major movable equipment, as defined in this chapter will be exempt from the ICF/ID cap and will be reimbursed prospectively based on Medicare principles of cost reimbursement. (3-19-07)

628. ICF/ID: COSTS EXCLUDED FROM THE CAP.
Certain costs may be excluded from the ICF/ID cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rate as provided in this Section to assure equitable reimbursement: (3-19-07)

01. Increases of More Than One Dollar Per Participant Day in Costs. Increases of more than one dollar ($1) per participant day in costs otherwise subject to the cap incurred by a facility as a result of changes in State or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs. (3-19-07)

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. (3-19-07)

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. (3-19-07)

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. (3-19-07)

d. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. (3-19-07)

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. (3-19-07)

f. When cost increases that have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount is included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. (3-19-07)

02. Excess Inflation. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount that actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the department. (3-19-07)

03. Cost Increases Greater Than Three Percent. When cost increases of greater than three percent (3%) of the projected interim rate that result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control. Prospective rates will be increased

and they will not be subject to the cap. However, they may be retrospectively adjusted by the Department. For the purposes of this Subsection, disaster does not include personal or financial problems. (3-19-07)

04. **Decreases**. In the event of state or federal law, rule, or policy changes that result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions. (3-19-07)

05. **Prospective Negotiated Rates**. Notwithstanding the provisions of Section 622 of these rules, the Director will have the authority to negotiate prospective rates for providers who would otherwise be subject to accept retrospective settlement. Such rates will not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this chapter. (3-19-07)

629. ICF/ID: LEGAL CONSULTANT FEES AND LITIGATION COSTS.
Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: (3-19-07)

01. **In General**. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. (3-19-07)

02. **Administrative Appeals**. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. (3-19-07)

03. **Other**. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. (3-19-07)

630. ICF/ID: PROPERTY RENTAL RATE REIMBURSEMENT.
ICFs/ID will be paid a property rental rate. Property taxes, property insurance, and depreciation expense or major moveable equipment will be reimbursed as costs exempt from limitations. The property rental rate does not include compensation for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. See Sections 56-108 and 56-109, Idaho Code, for further clarification. (3-19-07)

01. **Property Rental Rate**. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to the following: (3-19-07)

a. R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: (3-19-07)

b. "R" = the property rental rate. (3-19-07)

c. "Property Base" = eleven dollars and twenty-two cents ($11.22) except for ICF/ID living units not able to accommodate residents requiring wheelchairs beginning October 1, 1996. Property base = seven dollars and twenty-two cents ($7.22) for ICF/ID living units not able to accommodate residents requiring wheelchairs. (3-19-07)

d. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. For ICF/ID facilities, the most recent index available when it is first necessary to set a prospective rate for a period that includes all or part of the calendar year, will be used. (3-19-07)

e. "Age" of facility - The effective age of the facility in years will be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: (3-19-07)

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula:

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 630.01.d.ii.

If the result of this calculation, "r" is equal to or greater than two point zero (2.0), the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). (3-19-07)

ii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 630.01.d.i. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for "C" will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. (3-19-07)

iii. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. (3-19-07)

iv. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 630.01.d.iii. and 630.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of

the financial burden to the state of subsequent property rate increases for a current or successor provider. (3-19-07)

v. Effective October 1, 1996, for ICF/ID facilities, "age of facility" will be a revised age that is the lesser of the age established under other provisions of this Section or the age that most closely yields the rate allowable to existing facilities as of September 30, 1996, under Subsection 630.01 of these rules. This revised age will not increase over time. (3-19-07)

02. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Subsection 630.01 of these rules. (3-19-07)

631. ICF/ID: PROPERTY REIMBURSEMENT LIMITATIONS.
Beginning October 1, 1996, property costs of an ICF/ID will be reimbursed in accordance with Section 630 of these rules except as follows: (3-19-07)

01. Restrictions. No grandfathered rates or lease provisions other than lease provisions in Section 630 of these rules will apply to ICF/ID facilities. (3-19-07)

02. Home Office and Day Treatment Property Costs. Distinct parts of buildings containing ICF/ID living units may be used for home office or day treatment purposes. Reimbursement for the property costs of such distinct parts may be allowed if these areas are used exclusively for home office or day treatment services. The portion of property cost attributed to these areas may be reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for home office and day treatment property costs will not include costs reimbursed by, or covered by the property rental rate. Such costs will only be reimbursed as property cost if the facility clearly included space in excess of space normally used in such facilities. At a minimum to qualify for such reimbursement, a structure would have square feet per licensed bed in excess of the average square feet per licensed bed for other ICF/ID living units within four (4) licensable beds. (3-19-07)

03. Leases for Property. Beginning October 1, 1996, ICF/ID facilities with leases will be reimbursed as follows: (3-19-07)

a. The property costs related to ICF/ID living units other than costs for major movable equipment will be paid by a property rental rate in accordance with Section 630 of these rules. (3-19-07)

b. Leases for property other than ICF/ID living units will be allowable based on lease cost to the facility not to exceed a reasonable market rate, subject to other provisions of this chapter, and PRM principles including principles associated with related party leases. (3-19-07)

632. ICF/ID: SPECIAL RATES.
Section 56-117, Idaho Code, provides that the Department may pay facilities a special rate for care given to consumers who have medical or behavior long-term care needs beyond the normal scope of facility services. These individuals must have one (1) or more of the following behavior needs; additional personnel for supervision, additional behavior management, or additional psychiatric or pharmacology services. A special rate may also be given to consumers having medical needs that may include individuals needing ventilator assistance, certain medical pediatric needs, or individuals requiring nasogastric or intravenous feeding devices. These medical and behavior needs are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-265, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter and will be based on a per diem rate applicable to the incremental additional costs incurred by the facility. Payment for special rates will start with approval by the Department and be and reviewed at least yearly for continued need. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section 632 of these rules, will be excluded from the computation of payments or rates under other provisions of Section 56-265, Idaho Code, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (3-20-20)

01. Determinations. A determination to approve or not approve a special rate will be made on a consumer-by-consumer basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. (3-19-07)

02. **Approval**. Special rates will not be paid unless prior authorized by the Department. A special rate may be used in the following circumstances: (3-19-07)

a. New admissions to a community ICF/ID; (3-19-07)

b. For individuals currently living in a community ICF/ID when there has been a significant change in condition not reflected in the current rate; or (3-19-07)

c. The facility has altered services to achieve and maintain compliance with state licensing or federal certification requirements that have resulted in additional cost to the facility not reflected in their current rate. (3-19-07)

d. For the purpose of this rule, an emergency exists when the facility must incur additional behavioral or medical costs to prevent a more restrictive placement. (3-19-07)

03. **Reporting**. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. (3-19-07)

04. **Limitations**. The reimbursement rate paid will not exceed the provider's charges to other participants for similar services. (3-19-07)

633. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/ID FACILITIES.
Provisions of these rules do not apply to ICF/ID facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars ($5,000). (3-19-07)

634. (RESERVED)

YOUTH EMPOWERMENT SERVICES (YES)
HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 635-638)

635. YOUTH EMPOWERMENT SERVICES (YES) HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION.
Home and community-based services are provided through the HCBS State Plan option, as allowed in Section 1915(i) of the Social Security Act, for children who are YES program participants. HCBS state plan option services must be delivered in accordance with Sections 635 through 638 of these rules. (3-28-18)

636. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of Sections 635 through 638 of these rules, the following terms are used as defined below. (3-28-18)

01. **Idaho Behavioral Health Plan (IBHP)**. The Idaho Behavioral Health Plan is defined in IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Section 011. (3-28-18)

02. **Independent Assessment**. A comprehensive clinical diagnostic assessment and a Department-approved assessment tool to identify the child’s needs, strengths, and degree of functional impairment, administered by a Department-designated independent assessor. The assessment process also includes the following activities: (3-28-18)

a. Evaluation of the child’s current behavioral health, living situation, relationships, and family functioning; (3-28-18)

b. Contacts, as necessary, with significant individuals such as family and teachers; and (3-28-18)

c. A review of information regarding the child’s clinical, educational, social, and behavioral health,

and juvenile/criminal justice history. (3-28-18)

03. Person-centered Service Plan. The person-centered service plan identifies the participant's physical and behavioral health services and supports needs. The person-centered service plan will be reviewed and updated by the Department or its designated representative at least every twelve (12) months, upon the participant's request, when new services are needed, or when there is a significant change in the participant's condition. (3-28-18)

04. Serious Emotional Disturbance (SED). The term "serious emotional disturbance" is defined in Section 16-2403, Idaho Code. (3-28-18)

05. YES Program Participant. A YES program participant is an Idaho resident under eighteen (18) years of age with a serious emotional disturbance as determined by an independent assessment. (3-28-18)

637. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: ELIGIBILITY REDETERMINATION.
YES program participant eligibility will be redetermined by an independent assessment every twelve (12) months. The Department may extend participant eligibility to allow for redetermination if the independent assessment is unavoidably delayed. (3-28-18)

638. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
The following services are covered for YES participants: (3-28-18)

01. Respite Care. Respite care provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver of a YES program participant. Respite care is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Payment and administration of respite care services will be done through the IBHP and will be established by the Department in the IBHP contract. (3-28-18)

02. Person-Centered Planning. A person-centered planning team, comprised of the participant, family members, and other support persons significant to the participant, will direct the development of the person-centered service plan through a process approved by the Department. The process will include support necessary to enable the participant and their family to make informed choices and decisions concerning the person-centered service plan. (3-28-18)

639. -- 644. (RESERVED)

ADULT DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 645-659)

645. HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION.
Home and community-based services are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with developmental disabilities who do not meet the ICF/ID level of care. HCBS state plan option services must comply with Sections 310 through 319, and Sections 645 through 657 of these rules. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult Developmental Disabilities HCBS State Plan Option program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or a state plan amendment to the existing Adult Developmental Disabilities HCBS State Plan Option benefit. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. (3-13-20)T

646. COMMUNITY CRISIS SUPPORTS.
Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. (7-1-16)

647. COMMUNITY CRISIS SUPPORTS: ELIGIBILITY.
Prior to receiving community crisis supports, an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-16)

648. COMMUNITY CRISIS SUPPORTS COVERAGE AND LIMITATIONS.
Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (7-1-16)

01. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (7-1-16)

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (7-1-16)

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within seventy-two (72) hours of providing the service. (7-1-16)

649. DEVELOPMENTAL THERAPY.
The Department will pay for developmental therapy provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. (7-1-13)

650. DEVELOPMENTAL THERAPY: ELIGIBILITY.
Prior to receiving developmental therapy in a DDA an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code be eighteen (18) years of age or older, and live in the community. (7-1-13)

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental therapy must be recommended by a physician or other practitioner of the healing arts. (7-1-13)

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an assessment completed prior to the delivery of developmental therapy. (3-13-20)T

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-13)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in their life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental Therapy may be provided in home and community-based settings as described in Section 312 of these rules. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-16)

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-13)

02. **Excluded Services**. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

03. **Limitations on Developmental Therapy**. Developmental therapy may not exceed the limitations as follows: only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (3-13-20)T

652. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN ISP.

01. **Eligibility Determination**. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-13)

02. **Intake**. Prior to the delivery of developmental therapy: (7-1-13)

a. A DDA will obtain a participant's current medical, social, and developmental information from the Department or its designee. (7-1-13)

b. The participant must have an ISP that is authorized in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. Developmental therapy provided by the DDA must be included on the plan of service and be prior authorized by the Department or its designee before a participant can receive the service from the agency. (7-1-13)

03. **Documentation of Plan Changes**. Documentation of changes in the required plan of service or Program Implementation Plan must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If there are changes to a Program Implementation Plan that affect the type or amount of service on the plan of service, an addendum to the plan of service must be completed. (7-1-11)

653. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN IPP.

01. **Eligibility Determination**. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. (7-1-13)

02. **Intake**. Individuals using the Home and Community-Based Services (HCBS) waiver for the Aged and Disabled (A&D) or State Plan Personal Care Services and only requesting DDA services, have the option to access services through an Individual Program Plan. Individuals who select this option are not required to have a developmental disability plan developer. Services delivered through an Individual Program Plan must be authorized by the Department or its contractor and be based on the Aged and Disabled written Individual Service Plan as defined in Section 328 of these rules. Prior to the delivery of developmental therapy, a DDA must complete an Individual Program Plan (IPP) that meets the standards described below. (7-1-16)

03. Individual Program Plan (IPP) Definitions. The delivery of developmental therapy on a written plan of care must be defined in terms of the type, amount, frequency, and duration of the service. (7-1-16)

a. Type of service refers to the kind of service described in terms of: (7-1-11)

i. Group, individual, or family; and (7-1-11)

ii. Whether the service is home, community, or center-based. (7-1-11)

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. (7-1-11)

c. Frequency of service is the number of times service is offered during a week or month. (7-1-11)

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. (7-1-11)

04. Individual Program Plan (IPP). (7-1-13)

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. (7-1-11)

b. The planning process must include the participant, their legal guardian if one exists, and others the participant or their legal guardian chooses. The participant and their legal guardian if one exists must sign the IPP indicating they directed the person-centered planning process. The participant and their legal guardian if one exists must be provided a copy of the completed IPP by the DDA. A physician or other practitioner of the healing arts, the participant, and their legal guardian if one exists, must sign the IPP prior to initiation of any services identified within the plan. (7-1-16)

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations require written authorization by the participant, their legal guardian if one exists, and must be maintained in the participant's file. (7-1-13)

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. (7-1-11)

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: (7-1-11)

i. The participant's name and medical diagnosis; (7-1-11)

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; (7-1-11)

iii. The dated signature of the physician or other practitioner of the healing arts indicating their recommendation of the services on the plan; (7-1-11)

iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; (7-1-11)

v. A list of the participant's current personal goals and desired outcomes, interests, and choices; (7-1-16)

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences. An IPP objective must be developed for each priority need; (7-1-11)

vii. A list of measurable behaviorally stated objectives that correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; (7-1-11)

viii. The Developmental Specialist responsible for each objective; (7-1-13)

ix. The target date for completion of each objective; (7-1-11)

x. The review date; and (7-1-11)

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. (7-1-13)

05. Documentation of Plan Changes. Documentation of required Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: (7-1-13)

a. The reason for the change; (7-1-11)

b. Documentation of coordination with other services providers, where applicable; (7-1-11)

c. The date the change was made; and (7-1-11)

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant and their legal guardian if one exists. Changes in type, amount, or duration of services must be recommended by a physician or other practitioner of the healing arts. Such recommendations require written authorization by the participant and their legal guardian if one exists prior to the change. If the signatures of the participant or their legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. (7-1-13)

06. Home and Community-Based Person-Centered Planning. Individual Program Plans completed by a DDA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules and must be included in the participant’s individual service plan as described in Section 328 of these rules. (7-1-16)

654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. DDAs must obtain assessments required under Sections 507 through 515 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: (7-1-13)

a. Comprehensive Developmental Assessment; and (7-1-13)

b. Specific Skill Assessment. (7-1-13)

02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. (7-1-13)

a. Comprehensive Assessments. A comprehensive assessment must: (7-1-11)

i. Determine the necessity of the service; (7-1-11)

ii. Determine the participant's needs; (7-1-11)

iii. Guide treatment; (7-1-11)

iv. Identify the participant's current and relevant strengths, needs, and interests when these are applicable to the respective discipline; and (7-1-11)

b. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. (7-1-11)

c. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. To be considered current, assessments must be completed or updated at least every two (2) years for service areas in which the participant is receiving services on an ongoing basis. (7-1-13)

d. Comprehensive Developmental Assessment. A comprehensive developmental assessment must reflect a person's developmental status in the following areas: (7-1-13)

i. Self-care; (7-1-11)

ii. Receptive and expressive language; (7-1-11)

iii. Learning; (7-1-11)

iv. Gross and fine motor development; (7-1-11)

v. Self-direction; (7-1-11)

vi. Capacity for independent living; and (7-1-11)

vii. Economic self-sufficiency. (7-1-11)

03. Specific Skill Assessments. Specific skill assessments must: (7-1-13)

a. Further assess an area of limitation or deficit identified on a comprehensive assessment. (7-1-13)

b. Be related to a goal on the IPP or ISP. (7-1-13)

c. Be conducted by qualified professionals. (7-1-13)

d. Be conducted for the purposes of determining a participant’s skill level within a specific domain. (7-1-13)

e. Be used to determine baselines and develop the program implementation plan. (7-1-13)

04. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. (7-1-11)

a. General Requirements for Program Documentation. For each participant the following program documentation is required: (7-1-11)

i. Daily entry of all activities conducted toward meeting participant objectives. (7-1-11)

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and (7-1-11)

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional's dated initials. (7-1-11)

iv. Documentation of six (6) month and annual reviews by the Developmental Specialist that includes a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why they continue to need services. (7-1-13)

v. Signed, authorized plan as described in Section 513 of these rules. (7-1-16)

b. DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. (7-1-13)

05. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be developed within fourteen (14) days from the plan of service start date or receipt of the authorized plan of service and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. If consistent with the timeframes above, a participant's annual Program Implementation Plan is completed after the start date of the annual plan of service, the provider will address goals and objectives as agreed to by the participant until the annual Program Implementation Plan is complete and must document service provision related to these interim goals and objectives consistent with Section 654 of these rules. The Program Implementation Plan must include the following requirements: (7-1-16)

a. Name. The participant's name. (7-1-11)

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. (7-1-11)

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives authorized and agreed to in the required plan of service. (7-1-16)

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

e. Service Environments. Identification of the type of environment(s) where services will be provided. (7-1-11)

f. Target Date. Target date for completion. (7-1-11)

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

h. Home and Community-Based Services Requirements. All program implementation plans must meet home and community-based setting qualities defined in Section 313 of these rules. (7-1-16)

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (7-1-11)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-11)

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-11)

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-11)

ii. Passed a competency examination approved by the Department. (7-1-11)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-11)

d. Through the duration of the COVID-19 public health emergency, Development Specialists for adults may begin rendering services prior to completing the training requirements provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. (7-1-13)

03. Requirements for Collaboration with Other Providers. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. (3-20-14)

656. GENERAL STAFFING REQUIREMENTS.

01. Standards for Paraprofessionals Providing Developmental Therapy. When a paraprofessional provides developmental therapy, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410 and must meet the qualifications under Section 655 of these rules. A paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. For paraprofessionals to provide developmental therapy in a DDA, the agency must adhere to the following standards: (7-1-13)

a. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service or develop a Program Implementation Plan. These activities must be conducted by a professional qualified to provide the service. (7-1-13)

b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under their supervision, on a weekly basis or more often if necessary: (7-1-11)

i. Give instructions; (7-1-11)

ii. Review progress; and (7-1-11)

iii. Provide training on the program(s) and procedures to be followed. (7-1-11)

c. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under their supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). (7-1-11)

02. General Staffing Requirements for Agencies. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. 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. (7-1-13)

a. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and (7-1-11)

b. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. (7-1-11)

657. DEVELOPMENTAL THERAPY: PROVIDER REIMBURSEMENT.
Payment for developmental therapy provided by a DDA must be in accordance with rates established by the Department. (7-1-13)

658. COVID-19 PUBLIC HEALTH EMERGENCY RESIDENTIAL HABILITATION.
Through the duration of the COVID-19 public health emergency, the Department will pay for residential habilitation services, as described in Subsection 703.01 of these rules, provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Prior to receiving residential habilitation services from a DDA, an individual must be determined by the Department, or its contractor, to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. DDA's providing residential habilitation services must comply with any additional requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

659. -- 699. (RESERVED)

ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES
(Sections 700-719)

700. ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible adult participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs their mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult DD waiver program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or HCBS Attachment K amendment to the existing Adult Developmental Disability waiver. In the event

additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. (3-13-20)T

701. (RESERVED)

702. ADULT DD WAIVER SERVICES: ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following requirements: (7-1-11)

01. Age of Participants. DD waiver participants must be eighteen (18) years of age or older. (3-29-10)

02. Eligibility Determinations. The Department must determine that: (3-19-07)

a. The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and (3-19-07)

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. (3-19-07)

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs. (7-1-06)

03. Home and Community-Based Services Waiver Eligible Participants. A participant who is determined by the Department to be eligible for services under the Home and Community-Based Services Waivers for DD may elect not to utilize waiver services but may choose admission to an ICF/ID. (3-29-10)

04. Processing Applications. The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," as if the application was for admission to an ICF/ID, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. (3-19-07)

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (3-19-07)

06. Case Redetermination. (3-19-07)

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." Medical redetermination will be made at least annually by the Department, or sooner at the request of the participant, the self-reliance staff, provider agency, or physician. The sections cited implement and are in accordance with Idaho's approved State Plan with the exception of deeming of income provisions. (3-19-07)

b. The redetermination process will assess the following factors: (3-19-07)

i. The participant's continued need and eligibility for waiver services; and (3-19-07)

ii. Discharge from the waiver services program. (3-19-07)

07. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the home and community-based waiver for developmentally disabled participants will be limited to the projected number of users contained in the Department's approved waiver.

Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver of each new waiver year. (3-29-10)

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

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

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to 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 non-therapeutic activities that are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services that consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on their own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

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

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

i. Yard maintenance; (4-4-13)

ii. Minor home repair; (4-4-13)

iii. Heavy housework; (4-4-13)

iv. Sidewalk maintenance; and (4-4-13)

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

b. Chore activities may include the following: (4-4-13)

i. Washing windows; (4-4-13)

ii. Moving heavy furniture; (4-4-13)

iii. Shoveling snow to provide safe access inside and outside the home; (4-4-13)

iv. Chopping wood when wood is the participant's primary source of heat; and (4-4-13)

v. Tacking down loose rugs and flooring. (4-4-13)

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

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

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

04. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (4-4-13)

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

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

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

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

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. (4-4-13)

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

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

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

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

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

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

i. Devices, controls, or appliances that enable a participant to increase 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)

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

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

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

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

d. Would otherwise require extensive, routine supervision. (4-4-13)

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

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

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

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

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

10. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse licensed to practice in Idaho. (4-4-13)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services that provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. (3-13-20)T

13. Self-Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer-Directed Services." (3-19-07)

14. Place of Service Delivery. Waiver services may be provided in home and community settings as described in Section 312 of these rules. Approved places of services include the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (7-1-16)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

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

c. Residential Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

15. 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)

704. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process described in Sections 507 through 520 of these rules. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. (3-19-07)

02. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: (3-19-07)

a. Direct Service Provider Information that includes written documentation of 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; and (3-19-07)

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

iii. A statement 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 participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (3-19-07)

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (3-19-07)

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 704.01 of these rules and a copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (3-19-07)

c. In addition to the plan of service, all providers, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Sections 507 through 520 of these rules. (3-19-07)

03. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. (3-19-07)

04. Records Maintenance. In order to provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (3-19-07)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. 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 must 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: (3-19-07)

i. Be at least eighteen (18) years of age; (3-19-07)

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; (3-19-07)

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

v. Each staff person assisting with participant medications has successfully completed 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. (4-4-13)

vi. Residential habilitation service providers who provide direct care or services satisfactorily completed a criminal background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-13-20)T

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-19-07)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

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: (3-29-12)

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

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; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

f. Through the duration of the COVID-19 public health emergency, agency direct service staff may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

02. Residential Habilitation -- Certified Family Home (CFH). (3-29-12)

a. An individual who provides direct residential habilitation services in their own home must be

certified by the Department to operate a certified family home under IDAPA 16.03.19, "Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services they provide. (3-29-12)

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: (3-29-12)

i. Be at least eighteen (18) years of age; (3-29-12)

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (3-29-12)

iii. Have current CPR and First Aid certifications; (3-29-12)

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

v. Each CFH provider of residential habilitation services assisting with participant medications has successfully completed 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. (3-29-12)

vi. CFH providers of residential habilitation services who provide direct care and services have satisfactorily completed a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks;" and (3-13-20)T

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-29-12)

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: (3-29-12)

i. Purpose and philosophy of services; (3-29-12)

ii. Service rules; (3-29-12)

iii. Policies and procedures; (3-29-12)

iv. Proper conduct in relating to waiver participants; (3-29-12)

v. Handling of confidential and emergency situation that involve the waiver participant; (3-29-12)

vi. Participant rights; (3-29-12)

vii. Methods of supervising participants; (3-29-12)

viii. Working with individuals with developmental disabilities; and (3-29-12)

ix. Training specific to the needs of the participant. (3-29-12)

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: (3-29-12)

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; (3-29-12)

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; (3-29-12)

iii. Feeding; (3-29-12)

iv. Communication; (3-29-12)

v. Mobility; (3-29-12)

vi. Activities of daily living; (3-29-12)

vii. Body mechanics and lifting techniques; (3-29-12)

viii. Housekeeping techniques; and (3-29-12)

ix. Maintenance of a clean, safe, and healthy environment. (3-29-12)

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. (3-29-12)

g. Through the duration of the COVID-19 public health emergency, CFH providers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-13-20)T

03. Chore Services. Providers of chore services must meet the following minimum qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-13-20)T

04. 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; (3-19-07)

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 have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-13-20)T

05. Supported Employment. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or

other comparable standards, or meets 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 Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-13-20)T

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

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

07. **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)

08. **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)

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

10. **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. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (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)

11. **Skilled Nursing**. 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 Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-13-20)T

12. **Behavior Consultation or Crisis Management**. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (4-4-13)

b. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or (3-19-07)

c. Be a licensed pharmacist; or (3-19-07)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Residential Habilitation Agencies." (3-19-07)

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-13-20)T

13. **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. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks"; (3-13-20)T

d. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. (4-4-13)

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

14. **Service Supervision**. The plan of service that includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

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

706. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. **Fee for Service**. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. (3-19-07)

02. **Claim Forms**. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. (3-19-07)

03. **Rates**. The reimbursement rates 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 transportation. (3-19-07)

707. -- 719. (RESERVED)

SUB AREA: SERVICE COORDINATION SERVICES
(Sections 720-779)

720. SERVICE COORDINATION.
The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. These rules are not applicable to behavioral health service coordination, also known as case management services, provided under the Idaho Behavioral Health Plan (IBHP) included in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (3-20-14)

721. SERVICE COORDINATION: DEFINITIONS.
The following definitions apply for Sections 721 through 736 of these rules. (5-8-09)

01. Agency. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator. (5-8-09)

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. (3-19-07)

03. Conflict of Interest. A situation in which an agency or person directly or indirectly influences. or appears to influence the direction of a participant to other services for financial gain. (5-8-09)

04. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: (3-19-07)

a. Hospitalization; (3-19-07)

b. Loss of housing; (3-19-07)

c. Loss of employment or major source of income; (3-19-07)

d. Incarceration; or (3-19-07)

e. Physical harm to self or others, including family altercation or psychiatric relapse. (3-19-07)

05. Human Services Field. A particular area of academic study in health care, social services, education, behavioral science or counseling. (5-8-09)

06. Paraprofessional. An adult with a high school diploma or equivalency who has at least twelve (12) months supervised work experience with the population to whom they will be providing services. (5-8-09)

07. Person-Centered Planning. A planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family. (5-8-09)

08. Practitioner of the Healing Arts. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. (3-19-07)

09. Service Coordination. Service coordination is a case management activity that assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination is a brokerage model of case management. (5-8-09)

10. Service Coordination Plan. The service coordination plan, also known in these rules as the "plan," includes two components: (5-8-09)

a. An assessment that identifies the participant's need for service coordination as described in Section 730 of these rules; and (5-8-09)

b. A plan that documents the supports and services required to meet the service coordination needs of the participant as described in Section 731 of these rules. (5-8-09)

11. Service Coordination Plan Development. An assessment and planning process performed by a service coordinator using person-centered planning principles that results in a written service coordination plan. The plan must accurately reflect the participant's need for assistance in accessing and coordinating supports and services. (5-8-09)

12. **Service Coordinator**. An individual, excluding a paraprofessional, who provides service coordination to a Medicaid eligible participant, is employed by or contracts with a service coordination agency, and meets the training, experience, and other requirements in Section 729 of these rules. (5-8-09)

13. **Supports**. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of their choice. (3-19-07)

722. SERVICE COORDINATION SERVICES: ELIGIBILITY.
Participants identified in Sections 723 through 726 of these rules, who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for persons with intellectual disabilities, are eligible for service coordination. (3-19-07)

723. TARGETED SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
An individual is eligible to receive targeted service coordination if they meet the following requirements in this rule. (7-1-16)

01. **Age**. An adult eighteen (18) years of age or older. (3-29-10)

02. **Diagnosis**. Is diagnosed with a developmental disability, defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, that: (5-8-09)

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (5-8-09)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-19-07)

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration and individually planned and coordinated. (5-8-09)

03. **Need Assistance**. Requires and chooses assistance to access services and supports necessary to maintain their independence in the community. (5-8-09)

724. -- 725. (RESERVED)

726. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS UP TO THE AGE OF TWENTY-ONE.
To be eligible for children's service coordination, a participant must meet the following requirements in Subsections 726.01 through 726.03. Eligibility is determined initially and annually by the Department based on information provided by the service coordination agency or the family. All information necessary to make the eligibility determination must be received by the Department twenty (20) business days prior to the anticipated start date of any service coordination services. The eligibility determination will be made by the Department prior to the initiation of initial and ongoing plan development and services. (3-20-14)

01. **Age**. From the age of thirty-seven (37) months through the month in which their twenty-first birthday occurs. (5-8-09)

02. **Diagnosis**. Must have special health care needs requiring medical and multidisciplinary rehabilitation services identified by a physician or other practitioner of the healing arts to prevent or minimize a disability. (3-20-14)

03. **Need Assistance**. Medicaid-reimbursed service coordination services are not available for

participants whose needs can be met by other service coordination or case management resources, including paid and non-paid sources. The participant must have needs for service coordination for one (1) or more of the following problems: (3-20-14)

a. The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, child care setting, family, or community; (5-8-09)

b. The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; (5-8-09)

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; (5-8-09)

d. Further complications may occur as a result of the condition without provision of service coordination services; or (3-19-07)

e. The child requires multiple service providers and treatments. (3-19-07)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. (3-20-14)

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (5-8-09)

a. Taking a participant's history; (5-8-09)

b. Identifying the participant's needs and completing related documentation; and (5-8-09)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. (5-8-09)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant. The plan must be updated at least annually (or extended through the duration of the declared COVID-19 public health emergency) and as needed to meet the needs of the participant. (3-13-20)T

03. Referral and Related Activities. Activities that help link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. (3-20-14)

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days (the face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code), to determine whether the following conditions are met: (3-13-20)T

a. Services are being provided according to the participant's plan; (5-8-09)

b. Services in the plan are adequate; and (5-8-09)

c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. (5-8-09)

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access

community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. (5-8-09)

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. (5-8-09)

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section 646 through 648 of these rules. (7-1-16)

c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service. (5-8-09)

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (5-8-09)

07. Exclusions. Service coordination does not include activities that are: (5-8-09)

a. An integral component of another covered Medicaid service; (5-8-09)

b. Integral to the administration of foster care programs; (5-8-09)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (3-20-14)

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month. (3-20-14)

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours per year. (3-20-14)

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. Services must be prior authorized by the Department according to the direction provided in the Medicaid Provider Handbook available at www.idmedicaid.com. (3-20-14)

02. Service Coordination Plan Development. (5-8-09)

a. A written plan, described in Section 731 of these rules, must be developed and implemented within sixty (60) days after the participant chooses a service coordinator. (3-20-14)

b. The plan must be updated at least annually (or extended through the duration of the declared COVID-19 public health emergency) and amended as necessary. (3-13-20)T

c. The plan must address the service coordination needs of the participant as identified in the assessment described in Section 730 of these rules. (5-8-09)

d. The plan must be developed prior to ongoing service coordination being provided. (5-8-09)

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following: (3-19-07)

a. The name of the eligible participant. (5-8-09)

b. The name of the provider agency and the person providing the services. (5-8-09)

c. The date, time, duration, and place the service was provided. (5-8-09)

d. The nature, content, units of the service coordination received and whether goals specified in the plan have been achieved. (5-8-09)

e. Whether the participant declined any services in the plan. (5-8-09)

f. The need for and occurrences of coordination with any non-Medicaid case managers. (5-8-09)

g. The timeline for obtaining needed services. (5-8-09)

h. The timeline for re-evaluation of the plan. (5-8-09)

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. (5-8-09)

j. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. (5-8-09)

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. (5-8-09)

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. (5-8-09)

m. A copy of the informed consent form signed by the participant, parent, or legal guardian that documents that the participant has been informed of the purposes of service coordination, their rights to refuse service coordination, and their right to choose their service coordinator and other service providers. (5-8-09)

n. A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or their legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan. (3-20-14)

04. Documentation Completed by a Paraprofessional. Each entry completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation. (5-8-09)

05. Participant Freedom of Choice. A participant must have freedom of choice when selecting from

the service coordinators available to them. The service coordinator cannot restrict the participant's choice of other health care providers. (5-8-09)

06. Service Coordinator Contact and Availability. The frequency of contact, mode of contact, and person or entity to be contacted must be identified in the plan and must meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. At least every ninety (90) days, service coordinators must have face-to-face contact with each participant. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code. (3-13-20)T

a. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file. (5-8-09)

b. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the service coordinator will coordinate needed services after an emergency situation. (5-8-09)

07. Service Coordinator Responsibility Related to Conflict of Interest. Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must: (5-8-09)

a. Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. (5-8-09)

b. Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible. (5-8-09)

08. Agency Responsibility Related to Conflict of Interest. To assure that participants are protected from restrictions to their self-determination rights because of conflict of interest, the agency must guard against conflict of interest, and inform all participants and guardians of the risk. Each agency must have a document in each participant's file that contains the following information: (5-8-09)

a. The definition of conflict of interest as defined in Section 721 of these rules; (5-8-09)

b. A signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant parent, or legal guardian; and (5-8-09)

c. The participant's, parent's, or legal guardian's signature on the document. (5-8-09)

729. SERVICE COORDINATION: PROVIDER QUALIFICATIONS.
Service coordination services must be provided by an agency as defined in Section 721 of these rules. (5-8-09)

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. (3-19-07)

02. Supervision. The agency must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document: (5-8-09)

a. Each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision, and (5-8-09)

b. That a paraprofessional is not a supervisor. (5-8-09)

03. Agency Supervisor Required Education and Experience. (5-8-09)

a. Master's Degree in a a human services field from a nationally accredited university or college, and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Bachelor's degree in a human services field from a nationally accredited university or college, and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

c. Be a licensed registered nurse (RN) and have twenty-four (24) months supervised work experience with the population being served. (5-8-09)

04. Service Coordinator Education and Experience. (5-8-09)

a. Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or (5-8-09)

b. Be a licensed registered nurse (RN) and have twelve (12) months work experience with the population being served. (5-8-09)

c. When an individual meets the education or licensing requirements in Subsections 729.04.a. or 729.04.b. of this rule, but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience. (5-8-09)

05. Paraprofessional Education and Experience. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the plan. Paraprofessionals must have the following qualifications: (5-8-09)

a. Be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalency; (5-8-09)

b. Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of the service; and (5-8-09)

c. Have twelve (12) months supervised work experience with the population being served. (5-8-09)

06. Limitations on Services Delivered by Paraprofessionals. Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section 728.06 of these rules, one hundred eighty (180) day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan and they cannot supervise service coordinators or other paraprofessionals. (3-20-14)

07. Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-13-20)T

08. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. (3-19-07)

09. Individual Service Coordinator Case Loads. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. (5-8-09)

730. SERVICE COORDINATION: PLAN DEVELOPMENT -- ASSESSMENT.

01. Assessment Process. The service coordination assessment must be completed by a service coordinator as part of the person-centered planning process. The focus of the assessment is to identify the participant's need for assistance in gaining and coordinating access to care and services. The participant must be included in the assessment process. The parent or legal guardian, when appropriate, and pertinent service providers as identified by the participant must also be included during the assessment process. The assessment component is used to determine the prioritized needs and services of the participant and must be documented in the plan. When the participant is a child, the assessment must include identification of the family's needs to ensure the child's needs are met. (5-8-09)

02. Components of an Assessment. The components in the assessment of a participant's service coordination needs must document the following information; (5-8-09)

a. Basic needs; (5-8-09)

b. Medical needs; (5-8-09)

c. Health and safety needs; (5-8-09)

d. Therapy needs; (5-8-09)

e. Educational needs; (5-8-09)

f. Social and integration needs; (5-8-09)

g. Personal needs; (5-8-09)

h. Family needs and supports; (5-8-09)

i. Long range planning; (5-8-09)

j. Legal needs; and (3-20-14)

k. Financial needs. (3-20-14)

731. SERVICE COORDINATION: PLAN DEVELOPMENT -- WRITTEN PLAN.
The service coordination plan is developed using information collected through the assessment of the participant's service coordination needs. The plan must specify the goals and actions to address the service coordination needs of the participant identified in the assessment process. The plan must include goals developed using the person-centered planning process. (5-8-09)

01. Plan Implementation. The plan must identify activities required to respond to the assessed needs of the participant. (5-8-09)

02. Plan Content. Plans must include the following: (5-8-09)

a. A list of problems and needs identified during the assessment; (5-8-09)

b. Identification of each and any potential risk or substantiation that there are no potential risks. The plan must identify services and actions that will be implemented in case of a participant crisis situation. (5-8-09)

c. Concrete, measurable goals and objectives to be achieved by the participant; (5-8-09)

d. Reference to all services and contributions provided by the participant's supports including the actions, if any, taken by the service coordinator to develop the support system; (5-8-09)

e. Documentation of who has been involved in the service planning, including the participant's involvement; (5-8-09)

f. Schedules for service coordination monitoring, progress review, and reassessment; (5-8-09)

g. Documentation of unmet needs and service gaps including goals to address these needs or gaps; (5-8-09)

h. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery; and (5-8-09)

i. Time frames for achievement of the goals and objectives. (5-8-09)

03. Adult Developmental Disability Service Coordination Plan. The plan for adults with developmental disabilities must comply with and be incorporated into the participant's developmental disability plan of service identified in Section 513 of these rules. (7-1-16)

732. -- 735. (RESERVED)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

01. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. (3-19-07)

02. Payment for Service Coordination. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: (5-8-09)

a. Service coordination plan development defined in Section 721 of these rules. (5-8-09)

b. Face-to-face contact required in Subsection 728.06 of these rules. (3-20-14)

c. Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. (5-8-09)

d. Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. (3-19-07)

e. Referral and related activities associated with obtaining needed services as identified in the service coordination plan. (5-8-09)

03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. (5-8-09)

a. Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: (5-8-09)

i. During the last fourteen (14) days of an inpatient stay that is less than one hundred eighty (180) days in duration; or (5-8-09)

ii. During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. (5-8-09)

b. Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; (5-8-09)

c. Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. (5-8-09)

04. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. (3-19-07)

05. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. (5-8-09)

06. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. (5-8-09)

a. Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than four (4) billing units per hour. The following table is an example of minutes to billing units. (5-8-09)

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
8	23	1
22	38	2
37	53	3
52	68	4
67	83	5
82	98	6
97	113	7

(5-8-09)

b. Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. (5-8-09)

c. Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. (5-8-09)

d. Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. (5-8-09)

e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (5-8-09)

07. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. (3-19-07)

737. -- 779. (RESERVED)

SUB AREA: BREAST AND CERVICAL CANCER PROGRAM
(Sections 780-799)

780. BREAST OR CERVICAL CANCER PROGRAM THROUGH THE WOMEN'S HEALTH CHECK. Women who are determined eligible for Medicaid through the Women's Health Check program are eligible for enhanced Medicaid benefits until it is determined that cancer treatment has ended. (3-19-07)

781. BREAST OR CERVICAL CANCER PROGRAM: DEFINITIONS.

01. Primary Treatment. The initial action of treating a patient medically or surgically for cancer using conventional treatment modalities. (3-19-07)

02. Adjuvant Therapy. Treatment that includes either radiation or systemic chemotherapy, or both, as part of the plan of care. (3-19-07)

03. End of Treatment. Cancer treatment ends: (3-19-07)

a. When the woman's plan of care reflects a status of surveillance, follow-up, or maintenance mode; or (3-19-07)

b. If the woman's treatment relies on an unproven procedure, as referred to in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 390 in lieu of primary or adjuvant treatment. (3-19-07)

782. BREAST OR CERVICAL CANCER PROGRAM: ELIGIBILITY.
Women eligible for Medical Assistance, as provided for in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 802, will be covered while receiving either primary or adjuvant cancer treatment, or both. (3-19-07)

783. BREAST OR CERVICAL CANCER PROGRAM: PROCEDURAL REQUIREMENTS.
The Division of Medicaid, or its successor, is responsible for determining when a woman's treatment has ended. (3-19-07)

784. -- 999. (RESERVED)

APPENDIX A

IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Lower incisors: striking lingual of uppers at incisal	1/3 = 0	
Striking lingual of uppers at middle	1/3 = 1	
Striking lingual of uppers at gingival	1/3 = 2	
OPENBITE: (millimeters) *a,b		
Less than……	2 mm = 0	
	2-4 mm = 1	
	4+ mm = 2	
OVERJET: (millimeters) *a		
Upper…….	2-4 mm = 0	
Measure horizontally parallel to occlusal plane.	5-9 mm = 1	
	9+ mm = 2	
Lower……	0-1 mm = 0	

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
	2 mm = 1	
	3+ mm = 2	
POSTERIOR X-BITE: (teeth) *b		
Number of teeth in x-bite:	0-2 = 0	
	3 = 1	
	4 = 2	
TOOTH DISPLACEMENT: (teeth) *c, d, e		
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATIONSHIP:		
One side distal or mesial ½ cusp	= 0	
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	

TOTAL SCORE:_____

Scoring Definitions:

Impacted or blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids.

a) Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.
b) Missing teeth count as 1, if the space is still present.
c) Do not score teeth that are not fully erupted.
d) Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

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