Dear Senators LODGE, Broadsword & LeFavour, and
Representatives BLOCK, Nielsen & Rusche:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Dept. Of Health & Welfare:

IDAPA 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-0903)
(Proposed); and

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket Nos.
16-0310-0905, 16-0310-0906 and
16-0310-0907) (Proposed).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 11-13-09. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 12-11-09.

_____The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-2475, or send a written request to the address or FAX number indicated on the memorandum enclosed.

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Research & Legislation Staff - Paige Alan Parker

DATE: October 26, 2009

SUBJECT: Department of Health and Welfare - IDAPA 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-0903) (Proposed); and IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits (Docket Nos. 16-0310-0905, 16-0310-0906 and 16-0310-0907) (Proposed)

By these proposed rule dockets, the Department of Health and Welfare seeks to amend IDAPA 16.03.09, dealing with the Medicaid Basic Plan Benefits, and IDAPA 16.03.10, dealing with the Medicaid Enhanced Plan Benefits (Docket Nos. 16-0309-0903, 16-0310-0905, 16-0310-0906, and 16-0310-0907)(hereinafter collectively and individually "proposed rule"). The purpose of the proposed rule varies with the docket:

16-0309-0903 - revising rules dealing with: provider reimbursement to bring the rule into compliance with a recent court ruling; psychosocial rehabilitation (PSR) to match newly rewritten mental health rules; and paraprofessionals to align with licensure and DDA rules;
16-0310-0905 - complying with recommendations arising from the 2007 audit conducted by the Centers for Medicare and Medicaid Services (CMS) to change the payment methodology for children receiving Personal Care Services (PCS) regarding payment methodology for PCS homes; rules governing adult PCS and children's PCS; and PCS medication;
16-0310-0906 - complying with a recent court ruling by removing a requirement that developmental disability and PSR providers must contract with the school to provide school services; removing references to the Idaho State School and Hospital (ISSH) waiver that expired June 30, 2009; and revising the rule dealing with the negotiations for the plan of service since the Independent Assessor provider no longer reviews individual support plans; and

16-0310-0907 - removing the current fiscal intermediary (FI) rules for the Home and Community Based Services for the Aged and Disabled (HCBS A&D) waiver and replacing it with a reference to the Department's self-direction rules in order to align with changes being proposed in Docket No. 16-0313-0901 [reviewed in a separate memorandum]; removing certain references to requirements for FI services providers; and clarifying agency training and criminal history requirements that pertain to personal assistance agencies.

According to the Department, the proposed rule is authorized pursuant to sections 56-202(b), 56-203(g) and (i) and 56-250 through 56-257, Idaho Code. Section 56-202(b), Idaho Code, provides the Department with general and broad rulemaking authority. Section 56-203, Idaho Code, provides the Department with various powers, including to define persons entitled to medical assistance in such terms as will meet requirements for federal participation in medical assistance payments and to determine the amount, duration and scope of care and services to be purchased as medical assistance on behalf of needy eligible individuals. Sections 56-250 through 56-257, Idaho Code, are part of the Idaho Medicaid Simplification Act, adopted by the Legislature in 2006. Pursuant to section 56-253(8), Idaho Code, the Department's Director is given the authority to promulgate rules consistent with the Act.

According to the Department, no fee or charge is imposed by the proposed rule. Except for Docket No. 16-0310-0905, there is no impact to the General Fund by the proposed rule. With regard to Docket No. 16-0310-0905, the Department projects a total savings of $445,700, with General Fund portion of that savings being approximately 19% or $84,922.

According to the Department, informal negotiated rulemaking was done regarding Docket No. 16-0310-0907. No negotiated rulemaking was conducted on Docket Nos. 16-0309-0903 and 16-0310-0906 because the rulemaking is being done due to a recent court ruling that invalidated Medicaid rules for the billing of services delivered in schools. No negotiated rulemaking was conducted on Docket No. 16-0310-0905 because the rule changes are in response to a federal audit.

The Department states that public hearings will be held if requested in writing by 25 persons, a political subdivision or an agency, not later than Wednesday, October 21, 2009. All written comments must be delivered to the Department on or before October 28, 2009.

ANALYSIS

A. Docket No. 16-0309-0903

The proposed rule modifies the definition of "educational services," as applied to school-based services, by deleting a provision that the services alternately may be required by federal and state educational statutes or regulations. Section 850.02. The school-based service "collateral contact" for the Individualized Education Program (IEP) development and review

team meetings is not reimbursable under the proposed rule. "Collateral contact" is provided a referenced definition. Section 852.03.a.

The supervision required of a licensed professional counselor or licensed associate marriage and family therapist providing pyschotherapy services has been modified by the proposed rule to require supervision as per the rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists. The supervision required of a registered psychologist extender must be in compliance with the rules of the Idaho State Board of Psychological Examiners. Under the proposed rule, psychosocial rehabilitation services may be provided by a licensed practitioner of the healing arts, a licensed psychiatrist, or an associate marriage and family therapist, but not by a clinician or licensed pastoral counselor. A psychosocial rehabilitation specialist providing psychosocial rehabilitation services must meet the definition provided in the Department's Medicaid Enhanced Benefits rule. Section 854.07.

The proposed rule requires that service provided by paraprofessionals in schools and the Infant Toddler Program be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. These rules are listed for occupational therapy, physical therapy, speech-language pathology and developmental therapy. Specific requirements for assessment of paraprofessional competency, monthly orientation and training, student reevaluation, treatment plan adjustment, change in the student's condition, review of paraprofessionals working independently, and conditions when the paraprofessional is assisting in physical therapy are deleted by the proposed rule. Section 854.08.

A provision requiring a school or the Infant Toddler program to contract with a service provider when it does not deliver plan service through an employee has been deleted by the proposed rule. Section 855.

B. Docket No. 16-0310-0905

The proposed rule adds four new personal care services definitions: "children's PCS assessment," "natural supports," "personal care services (PCS)" and "PCS family alternative care home." "Personal care services (PCS)" are a range of medically-oriented care services related to a participant's physical or functional requirements that are provided in the participant's home or personal residence, but do not include housekeeping or skilled nursing care. Section 301. None of these terms has a statutory definition.

One of the requirements for a prior authorized payment of personal care services by the Regional Medicaid Services (RMS) is that a child participant have a children's PCS assessment completed. Section 302.02.b. The list of PCS services that a provider must provide has been rearranged by the proposed rule and is unchanged, except for assisting the participant with physician ordered medications (in accordance with Board of Nursing rule). Section 303.01. Under the proposed rule, certain non-medical tasks may be included within the provided PCS

services if no natural supports are available. Section 302.02. The proposed rule also provides that a PCS Family Alternate Care Home qualifies as the participant's own home or personal residence where PCS services may be provided. Section 302.03.

Included among the items a plan of care may be based upon is a children's PCS assessment. Section 304.01.a. The proposed rule requires that all PCS services must be prior authorized by the Department. Authorizations are based on: the children's PCS assessment or Uniform Assessment Instrument for adults; the individual service plan; and any other medical information that supports medical need. Section 304.03.

Under the proposed rule, the Department, rather than Medicaid, will establish Personal Assistance Agency rates for personal assistance services, based on the Weighted Average Hourly Rates (WAHR), which are based on an annual poll of all Idaho nursing facilities and Intermediate Care Facilities for the Mentally Retarded conducted by Medicaid. The rate is the WAHR plus 55% of WAHR as a supplemental component to cover travel, administration, training and all payroll taxes and fringe benefits. Section 307.04. This rate calculation is far simpler than the formula used under the existing rule. The same 1.55 times WAHR calculation is used to establish the payment rate for PCS Family Alternate Care Homes. Section 307.08.

C. Docket No. 16-0310-0906

The reference to ISSH has been eliminated throughout the proposed rule.

The proposed rule eliminates the requirements that a psychosocial rehabilitative services (PRS) agency has a contract with the school or the Infant Toddler program prior to delivering any services in a school-based setting, sections 124.09 and 653.05, and that the school or Infant Toddler program must bill for such services, section 140.

The proposed rule clarifies that the participant and the plan developer will have the opportunity to negotiate the plan of service with the Department's care manager if the services requested on the plan fall outside the individualized budget or do not reflect the participant's assessed needs. Section 513.09.

D. Docket No. 16-0310-0907

The proposed rule eliminates the definitions of "fiscal intermediary agency," section 011, "employer of record" and "employer of fact." section 321. Thus, instead of providing "fiscal intermediary" services, a Personal Assistance Agency may provide "financial management" services in accordance with the Department's consumer-directed services rule. Sections 306.01 and 329.01. Other references to "fiscal intermediary"services are deleted by the proposed rule. Sections 326.05, 328 and 329.

The proposed rule requires eligibility for aged or disabled waiver services to be in

accordance with the aged or disability waiver eligibility requirements rather than the nursing facility service eligibility requirements and need determination criteria. Section 323.01.a.

SUMMARY

The Department's proposed rule appears to be authorized under sections 56-202(b), 56-203 and 56-253(8), Idaho Code.

cc: Department of Health and Welfare
Tamara Prisock, Susan Choules, Lauren Ertz and Susan Scheuerer

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-0903

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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

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

Due to a recent court ruling stating that the Idaho Medicaid program cannot limit the "place of service" where medically necessary services can be delivered, revisions are being made to the rules dealing with provider reimbursement. Also, psychosocial rehabilitation rules will be revised to match new rewritten mental health rules. Finally, rules pertaining to paraprofessionals will be revised to align with licensure rules and DDA rules.

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

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

There is no fiscal impact to the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done due to a recent court ruling that invalidated Medicaid rules for the for the billing of services delivered in schools.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lauren Ertz at (208) 287-1169.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2009.

DATED this 14th day of August, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
dhwrules@dhw.idaho.gov e-mail

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-0903

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-30-07)

02. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or as educational facilities, which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students, and which are included in the individual educational plan for the participant ~~*or required by federal and state educational statutes or regulations*~~. ~~*(3-30-07)*~~( )

03. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts, charter schools, and the Idaho Infant Toddler program under the Individuals with Disabilities Education Act (IDEA). (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

852. SCHOOL-BASED SERVICE - COVERAGE AND LIMITATIONS.
The Department will pay school districts, charter schools, and the Idaho Infant Toddler Program, for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (3-30-07)

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (3-30-07)

a. Vocational Services. (3-30-07)

b. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. (3-30-07)

c. Recreational Services. (3-30-07)

02. Evaluation And Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-30-07)

a. Recommended or Referred by a Physician or Other Practitioner of the Healing Arts. Be recommended or referred by a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals; (3-30-07)

b. Conducted by Qualified Professionals. Be conducted by qualified professionals for the respective discipline as defined in Section 854 of these rules; (3-30-07)

c. Directed Toward Diagnosis. Be directed toward a diagnosis; and (3-30-07)

d. Recommend Interventions. Include recommended interventions to address each need. (3-30-07)

03. Reimbursable Services. School districts, charter schools, and the Idaho Infant Toddler program can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other practitioner of the healing arts licensed and approved by the state of Idaho to make such recommendations or referrals for the Medicaid services for which the school district, charter

school, or Idaho Infant Toddler Program is seeking reimbursement. (3-30-07)

a. Collateral Contact. Consultation or treatment direction about the student to a significant other in the student's life may be face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, or general parent education, or for ~~*treatment*~~ the Individualized Education Program (IEP) development and review team meetings, even when the parent is present, is not reimbursed. The term collateral contact is defined in Subsection 010.16 of these rules. ~~*(3-30-07)*~~( )

b. Developmental Therapy and Evaluation. Developmental therapy may be billed, including evaluation and instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability. (3-30-07)

c. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be ordered by a physician and prior authorized, based on medical necessity, in order to be billed. Authorized items must be used at school or for the Idaho Infant Toddler Program at the location where the service is provided. Equipment that is too large or unsanitary to transport from home to school may be covered if prior authorized. The equipment and supplies must be used for the student's exclusive use and transfer with the student if the student changes schools. Equipment no longer usable by the student, may be donated to the school or Idaho Infant Toddler Program by the student. (3-30-07)

d. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. (3-30-07)

e. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. (3-30-07)

f. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements such as basic personal care and grooming; assistance with bladder or bowel requirements; assistance with eating (including feeding), or other tasks delegated by a licensed professional nurse (RN). (3-30-07)

g. Physical Therapy and Evaluation. (3-30-07)

h. Psychological Evaluation. (3-30-07)

i. Psychotherapy. (3-30-07)

j. Psychosocial Rehabilitation (PSR) Services and Evaluation. Psychosocial rehabilitation (PSR) services and evaluation services to assist the student in gaining and utilizing skills necessary to participate in school. ~~*such as t*~~Training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, study skills, and coping skills are types of interventions that may be reimbursed. This service is to prevent placement of the student into a more restrictive educational situation. See IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 123 for a description of ~~*individual and group*~~ PSR services. ~~*(3-30-07)*~~( )

k. Intensive Behavioral Intervention (IBI). Intensive behavioral interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. Professionals may provide consultation to parents and to other staff who provide therapy for the child in other disciplines to assure successful integration and transition from IBI to other therapies and environments. (3-30-07)

l. Speech/Audiological Therapy and Evaluation. (3-30-07)

m. Social History and Evaluation. (3-30-07)

n. Transportation Services. School districts, charter schools, and the Idaho Infant Toddler programs can receive reimbursement for mileage for transporting a student to and from home, school, or location of services when: (3-30-07)

i. The student requires special transportation assistance such as a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student and ordered by a physician; (3-30-07)

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-30-07)

iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; (3-30-07)

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-30-07)

v. The mileage, as well as the services performed by the attendant, are documented. See Section 854 of these rules for documentation requirements. (3-30-07)

o. Interpretive Services. Interpretive services needed by a student who does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (3-30-07)

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; (3-30-07)

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-30-07)

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

854. SCHOOL-BASED SERVICE - PROVIDER QUALIFICATIONS AND DUTIES.
In addition to the evaluations and maintenance of the plans, the following documentation must be maintained by the provider and retained for a period of six (6) years: (3-30-07)

01. Service Detail Reports. A service detail report which includes: (3-30-07)

a. Name of student; (3-30-07)

b. Name and title of the person providing the service; (3-30-07)

c. Date, time, and duration of service; (3-30-07)

d. Place of service, if provided in a location other than school; and (3-30-07)

e. Student's response to the service. (3-30-07)

02. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. (3-30-07)

03. Documentation of Qualifications of Providers. (3-30-07)

04. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. (3-30-07)

05. Parental Notification. School districts, charter schools, and the Idaho Infant Toddler programs must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.06 of this rule. (3-30-07)

06. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district, charter school, or Idaho Infant Toddler Program billing for Medicaid services must act in cooperation with students' parents and with community and state agencies and professionals who provide like Medicaid services to the student. (3-30-07)

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts, charter schools, and the Idaho Infant Toddler program must ensure that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration or the service(s). The school district must provide the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and (3-30-07)

b. Notification to Primary Care Physician. School districts, charter schools, and the Idaho Infant Toddler program must request the name of the student's primary care physician from the parent or guardian so the school program can share health-related information with the physician with written consent from the parent or guardian. The following information must be sent to the student's primary care physician: (3-30-07)

i. Results of evaluations within sixty (60) days of completion; (3-30-07)

ii. A copy of the cover sheet and services page within thirty (30) days of the plan meeting; and (3-30-07)

iii. A copy of progress notes, if requested by the physician, within sixty (60) days of completion. (3-30-07)

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district, charter school, or Idaho Infant Toddler Program must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. (3-30-07)

d. Parental Consent to Release Information. School districts, charter schools, and the Idaho Infant Toddler program: (3-30-07)

i. Must obtain consent from the parent to release information regarding education-related services, in accordance with Federal Education Rights and Privacy Act (FERPA) regulations; (3-30-07)

ii. Must document the parent's denial of consent if the parent refuses to consent to the release of information regarding education-related services, including release of the name of the student's primary care physician. (3-30-07)

07. Provider Staff Qualifications. Medicaid will only reimburse for services provided by qualified staff. See Subsection 854.08 of this rule for the limitations and requirements for paraprofessional service providers. The following are the minimum qualifications for professional providers of covered services: (3-30-07)

a. Collateral Contact. Contact and direction must be provided by the professional who provides the treatment to the student. (3-30-07)

b. Developmental Therapy and Evaluation. Must be provided by or under the direction of a

developmental specialist, as set forth in IDAPA 16.04.11, "Developmental Disabilities Agencies." Certified special education teachers are not required to take the Department-approved course indicated in IDAPA 16.04.11 and be certified as a Developmental Specialist, Child. Only those school personnel who are working under a Letter of Authorization or as a Specialty Consultant must meet the certification requirements in IDAPA 16.04.11. (3-30-07)

c. Medical Equipment and Supplies. See Subsection 852.03 of these rules. (3-30-07)

d. Nursing Services. Must be provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) licensed to practice in Idaho. (3-30-07)

e. Occupational Therapy and Evaluation. Must be provided by or under the supervision of an individual qualified and registered to practice in Idaho. (3-30-07)

f. Personal Care Services. Must be provided by or under the direction of, a licensed professional nurse (RN) or licensed practical nurse (LPN), licensed by the State of Idaho. When services are provided by a CNA, the CNA must be supervised by an RN. Medically-oriented services having to do with the student's physical or functional requirements, such as basic personal care and grooming, assistance with bladder or bowel requirements, and assistance with eating (including feeding), must be identified on the plan of care and may be delegated to an aide in accordance with IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (3-30-07)

g. Physical Therapy and Evaluation. Must be provided by an individual qualified and licensed as a physical therapist to practice in Idaho. (3-30-07)

h. Psychological Evaluation. Must be provided by a: (3-30-07)

i. Licensed psychiatrist; (3-30-07)

ii. Licensed physician; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Psychologist extender registered with the Bureau of Occupational Licenses; or (3-30-07)

v. Certified school psychologist. (3-30-07)

i. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: (3-30-07)

i. Psychiatrist, M.D.; (3-30-07)

ii. Physician, M.D.; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Licensed clinical social worker; (3-30-07)

v. Licensed clinical professional counselor; (3-30-07)

vi. Licensed marriage and family therapist; (3-30-07)

vii. Certified psychiatric nurse (R.N.), as described in Subsection 707.~~0~~13 of these rules; ~~(3-30-07)~~( )

viii. Licensed professional counselor whose provision of psychotherapy is supervised ~~by persons qualified under Subsections 854.07.i.i. through 854.07.i.vii. of this rule~~ in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; ~~(3-30-07)~~( )

ix. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; ~~or~~ ~~(3-30-07)~~( )

x. ~~Psychologist extender registered with the Bureau of Occupational Licenses.~~ Licensed associate marriage and family therapist whose provision of psychotherapy is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or ~~(3-30-07)~~( )

xi. Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ( )

j. Psychosocial Rehabilitation. Must be provided by a: (3-30-07)

i. Licensed physician, ~~or~~ licensed practitioner of the healing arts, or licensed psychiatrist; ~~(3-30-07)~~( )

ii. Licensed master's level psychiatric nurse; (3-30-07)

iii. Licensed psychologist; (3-30-07)

iv. Licensed clinical professional counselor or professional counselor; (3-30-07)

v. Licensed marriage and family therapist or associate marriage and family therapist; ~~(3-30-07)~~( )

vi. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-30-07)

vii. Psychologist extender registered with the Bureau of Occupational Licenses; (3-30-07)

~~viii. Clinician;~~ ~~(3-30-07)~~

~~ix. Licensed pastoral counselor;~~ ~~(3-30-07)~~

~~x~~viii. Licensed professional nurse (RN); (3-30-07)

~~x~~ix. Psychosocial rehabilitation specialist as defined in ~~Section 456 in these rules~~ IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 131; ~~(3-30-07)~~( )

x~~ii~~. Licensed occupational therapist; (3-30-07)

xi~~ii~~. Certified school psychologist; or (3-30-07)

xi~~v~~i. Certified school social worker. (3-30-07)

k. Intensive Behavioral Intervention. Must be provided by or under the direction of a qualified professional who meets the requirements set forth in IDAPA 16.04.11 "Developmental Disabilities Agencies." (3-30-07)

l. Speech/Audiological Therapy and Evaluation. Must be provided by or under the direction of a speech pathologist or audiologist who possesses a certificate of clinical competence from the American Speech, Language and Hearing Association (ASHA); or who will be eligible for certification within one (1) year of employment. Personnel records must reflect the expected date of certification. (3-30-07)

m. Social History and Evaluation. Must be provided by a licensed professional nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. (3-30-07)

n. Transportation. Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (3-30-07)

08. Paraprofessionals. ~~*Paraprofessionals, such as aides or therapy technicians, may be used by the school/Infant Toddler program*~~ The schools and Infant Toddler Program may use paraprofessionals to provide developmental therapy; occupational therapy; physical therapy; and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be ~~*within the scope of practice of an aide or therapy technician*~~ delegated and supervised by a professional therapist as defined by the ~~*scope of practice of the therapy professional*~~ appropriate licensure and certification rules. The portions of the treatment plan which can be delegated to the paraprofessional must be identified in the IEP or IFSP. ~~*(3-30-07)*~~( )

a. ~~*Competency of Paraprofessional. The professional must have assessed the competence of the paraprofessional or aide to perform assigned tasks.*~~ Occupational Therapy. Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for supervision and service requirements. ~~*(3-30-07)*~~( )

b. Physical Therapy. Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for supervision and service requirements ( )

~~*b*~~**c.** ~~*Monthly Orientation. The paraprofessional, on a monthly basis, must be given orientation and training on the program and procedures to be followed.*~~ Speech-Language Pathology. Refer to IDAPA 24.23.01, "Rule of the Speech and Hearing Services Licensure Board," for supervision and service requirements for speech-language pathology. ~~*(3-30-07)*~~( )

~~*c*~~**d.** ~~*Reevaluation. The professional must reevaluate the student and adjust the treatment plan as their individual practice dictates.*~~ Developmental Therapy. Refer to IDAPA 16.04.11, "Developmental Disabilities Agencies," for supervision and service requirements. ~~*(3-30-07)*~~( )

~~***d.*** *Changes in Condition. Any changes in the student's condition not consistent with planned progress or treatment goals necessitates a documented reevaluation by the professional before further treatment is carried out.* *(3-30-07)*~~

~~***e.*** *Review of Independent Paraprofessional. If the paraprofessional works independently there must be a review conducted by the appropriate professional at least once per month. This review will include the dated initials of the professional conducting the review.* *(3-30-07)*~~

~~***f.*** *Utilizing Paraprofessional to Assist in Provision of Physical Therapy. In addition to the above, if a paraprofessional is utilized to assist in the provision of actual physical therapy they may do so only when the following conditions are met:* *(3-30-07)*~~

~~*i. Student reevaluation must be performed and documented by the supervising PT every five (5) visits or once a week if treatment is performed more than once per day.* *(3-30-07)*~~

~~*ii. The number of PTAs utilized in any practice or site, must not exceed twice in number the full time equivalent licensed PTs.* *(3-30-07)*~~

855. SCHOOL-BASED SERVICE - PROVIDER REIMBURSEMENT.
Payment for health-related services provided by school districts, charter schools, and the Idaho Infant Toddler program must be in accordance with rates established by the Department. (3-30-07)

01. Payment in Full. Providers of services must accept as payment in full the school district, charter school, or Idaho Infant Toddler Program payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. (3-30-07)

02. Third Party. For requirements regarding third party billing, see Section 215 of these rules. (3-30-07)

~~*03. Contracted Providers. When an employee of a school district, charter school, or Idaho Infant Toddler program does not deliver the services identified on the plan, the school district, charter school, or Idaho Infant Toddler Program must contract with a service provider to deliver the services and bill Medicaid for the contracted services. The contracted service provider must not bill Medicaid or the Medicaid participant. (3-30-07)*~~

0~~4~~3. **Recoupment of Federal Share**. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. (3-30-07)

0~~5~~4. **Matching Funds**. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts and charter schools must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: (3-30-07)

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. (3-30-07)

b. School districts and charter schools will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. (3-30-07)

c. The Department will hold matching funds in an interest bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. (3-30-07)

d. The payments to the districts will include both the federal and non-federal share (matching funds). (3-30-07)

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. (3-30-07)

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle. (3-30-07)

g. The Department will provide the school districts a monthly statement which will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. (3-30-07)

h. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay the Department. (3-30-07)

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0905

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56- 202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, October 21, 2009.

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

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

These rules are being amended in response to the federal audit conducted by Centers for Medicare and Medicaid Services (CMS) for the period of July 1, 2006, through June 30, 2007, on the Personal Care Services (PCS) program. In order to comply with the recommendations from CMS, the Department is changing the payment methodology for children receiving PCS in a PCS home and establishing rules specific to PCS for children.

The following is the summary of the proposed changes:

1. Update the current rules for Personal Care Services (PCS) to reflect changes in the payment methodology for PCS homes;

2. Separate, align, clarify, and augment the rules that govern adult PCS and children's PCS; and

3. Clarify PCS medication rules.

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

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

The projected fiscal impact is a total savings of $445,700; this includes state funds and federal matching funds. The projected savings to the state general fund is approximately $84,922.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted. Negotiated rulemaking was not conducted because these rule changes are being made in response to a federal audit.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Choules at (208) 364-1891.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, October 28, 2009.

DATED this 2nd day of September, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-0905

301. ~~*(RESERVED)*~~ 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. ( )

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. ( )

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. ( )

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. ( )

302. PERSONAL CARE SERVICES - ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." (3-19-07)

02. Other Eligibility Requirements. Regional Medicaid Services (RMS) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: (3-19-07)

a. The RMS finds that the participant is capable of being maintained safely and effectively in his own home or personal residence using PCS. (3-19-07)

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed~~.~~, ~~*A UAI is not to be completed for a child participant*~~ or a child for whom a children's PCS assessment has been completed; ~~*(3-19-07)*~~( )

c. The RMS reviews the documentation for medical necessity; and (4-2-08)

d. The participant has a plan of care. (4-2-08)

03. State Plan Option. A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds he requires PCS due to a medical condition that impairs his physical or mental function or independence. (3-19-07)

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. (3-19-07)

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." RMS must make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QMRP, or the physician. (4-2-08)

b. The medical redetermination must assess the following factors: (3-19-07)

i. The participant's continued need for PCS; (3-19-07)

ii. Discharge from PCS; and (3-19-07)

iii. Referral of the participant from PCS to a nursing facility. (3-19-07)

303. PERSONAL CARE SERVICES ~~*(PCS)*~~ - 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. ~~*Assisting the participant with physician-ordered medications that are ordinarily self-administered, such as opening the packaging or reminding the participant to take medications*~~ Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; ~~*(3-19-07)*~~( )

d. ~~*Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need*~~ The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities; ~~*(3-19-07)*~~( )

e. ~~*The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the developmentally disabled participant*~~ 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; ~~*(3-19-07)*~~( )

f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met: (3-19-07)

i. The task is not complex and can be safely performed in the given participant care situation; (3-19-07)

ii. A Licensed Professional 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: ~~(3-19-07)~~( )

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 only in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home or a Residential Care or Assisted Living Facility, or a PCS Family Alternate Care Home. The following living situations are specifically excluded as a personal residence: ~~(3-19-07)~~( )

a. Certified nursing facilities or hospitals. (3-19-07)

b. Licensed Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). (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 Care or Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." The Personal Assistance Agency and the participant who lives in his own home are responsible to prepare the plan of care. (3-19-07)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: ~~(3-19-07)~~( )

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

ii. The results of the UAI for adults, the ~~*Personal Assistance Agency's assessment for*~~ children's PCS assessment and, if applicable, the QMRP's assessment and observations of the participant; and ~~(3-19-07)~~( )

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)

02. Service Supervision. The delivery of PCS may be overseen by a licensed professional nurse (RN) or Qualified Mental Retardation Provider (QMRP). The RMS must identify the need for supervision. (3-19-07)

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

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

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

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

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

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the RMS, may receive oversight by a QMRP as defined in 42 CFR 483.430. Oversight must include: (3-19-07)

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

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

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

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

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

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

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

c. Any other medical information that supports the medical need. ( )

0~~3~~4. PCS Record Requirements for a Participant in His Own Home. The PCS records must be maintained on all participants who receive PCS in their own homes or in a PCS Family Alternate Care Home. ~~(3-19-07)~~( )

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

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

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

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

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

b. Participant's Signature. The participant must sign the record of service delivery verifying that the services were delivered. The RMS may waive this requirement if it determines the participant is not able to verify the service delivery. (3-19-07)

c. A copy of the information required in Subsection 304.03 of these rules must be maintained in the participant's home unless the RMS authorizes the information to be kept elsewhere. Failure to maintain this information may result in recovery of funds paid for undocumented services. (3-19-07)

d. 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 304.03 of these rules. (3-19-07)

e. Participant in a Residential or Assisted Living Facility. The PCS record requirements for participants in Residential Care or Assisted Living Facilities are described in IDAPA 16.03.22. "Residential Care or Assisted Living Facilities in Idaho." (3-19-07)

f. Participant in a Certified Family Home. The PCs record requirements for participants in Certified Family Homes are described in IDAPA 16.03.19, "Rules Governing Certified Family Homes." (3-19-07)

0~~4~~5. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the RMS and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record.

(3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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 on an annual basis according to Section 39-5606, Idaho Code. 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)

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 RMS 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 307.07 of these rules. (3-19-07)

03. Weighted Average Hourly Rates. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/MR, 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 ~~for~~ in calculating the reimbursement rate to be effective on July 1st of that year. ~~(3-19-07)~~( )

04. Payment ~~Levels~~ for ~~PAA~~ Personal Assistance Agency. ~~Medicaid~~ The Department will ~~then~~ establish ~~payment levels for~~ Personal Assistance ~~Agencies~~ Agency rates for personal assistance services ~~as follows:~~
~~(3-19-07)~~

~~**a.** Weekly service needs of zero to sixteen (0-16) hours under the State Medicaid Plan, or a HCBS waiver~~ based on the WAHR, plus the WAHR times a fifty-five percent (55%) supplemental component to cover travel, administration, training, and all payroll taxes and fringe benefits, as follows:

Personal Assistance Agencies	WAHR x 1.55	=	$ amount/hour

~~(3-19-07)~~( )

~~**b.** Extended visit, one (1) child (eight and one-quarter (8.25) hours up to twenty-four (24) hours):~~

~~Personal Assistance Agencies~~	~~(WAHR x actual hours of care up to 5 hours x 1.55) plus ($.65 x 1.55 hours on site on-call)~~	~~=~~	~~$ amount/hour~~
~~Licensed Child Foster Homes~~	~~(WAHR x actual hours of care up to 5 hours x 1.22) plus ($.65 x 1.22 x actual hours on site on-call)~~	~~=~~	~~$ amount/hour~~

~~(3-19-07)~~

~~**c.** Extended visit, two (2) children (eight and one-quarter (8.25) hours up to twenty-four (24) hours):~~

~~Personal Assistance Agencies~~	~~(WAHR x actual hours of care up to 4 hours) x (1.55 plus $.65 x 1.55 x hours on site on-call)~~	~~=~~	~~$ amount/hour~~
~~Licensed Child Foster Homes~~	~~(WAHR x hours actual care up to 4 hours x 1.22) plus ($.65 x 1.22 x hours on site on-call)~~	~~=~~	~~$ amount/hour~~

~~(3-19-07)~~

05. Payment Levels for Adults in Residential Care or Assisted Living Facilities or Certified Family Homes. Adult participants living in Residential Care or Assisted Living Facilities (RCALF) 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, mental retardation, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, mental retardation, 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 RMS. (3-19-07)

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 RMS. (3-19-07)

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMS. (3-19-07)

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, plus the product of the WAHR times fifty-five percent (55%) less the current payroll tax and fringe benefit rate to cover travel, administration, and training, as follows:

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x (1.55 minus payroll taxes and fringe benefits cost percentage)	=	$ amount/week

( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0906

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 21, 2009.

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

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

Due to a recent court ruling stating that the Idaho Medicaid program cannot limit the "place of service" where medically necessary services can be delivered, the requirement that developmental disability and psychosocial rehabilitation providers must contract with the school to provide services is being removed from this rule. Also, since the Idaho State School and Hospital (ISSH) Waiver expired June 30, 2009, references to the ISSH Waiver are being removed from the rules. Finally, as of July 1, 2009, the Independent Assessor Provider no longer reviews individual support plans, therefore, revisions will be made to the rule dealing with the negotiations for the plan of service.

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

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

There is no fiscal impact to the state general fund due to this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done due to a recent court ruling that invalidated Medicaid rules for the for the billing of services delivered in schools.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Lauren Ertz at (208) 287-1169.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2009.

DATED this 14th day of August, 2009.

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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-0906

124. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - COVERAGE AND LIMITATIONS.
The following service limitations apply to PSR agency services, unless otherwise authorized by the Department. (5-8-09)

01. Assessment. Assessment services must not exceed six (6) hours per participant annually. The following assessments are included in this limitation: (5-8-09)

a. Intake Assessment; (5-8-09)

b. Comprehensive Diagnostic Assessment. This assessment must be completed for each participant at least once annually; (5-8-09)

c. Functional Assessment. (5-8-09)

d. Psychological and Neuropsychological Assessments. The duration of this type of assessment is determined by the participant's benefits and the presenting reason for such an assessment. (5-8-09)

e. Occupational Therapy Assessment. The duration of this type of assessment is determined by the participant's benefits and the presenting reason for such an assessment. (5-8-09)

02. Individualized Treatment Plan. Two (2) hours per year per participant per provider agency are available for treatment plan development. (3-19-07)

03. Psychotherapy. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours annually. Services beyond six (6) hours weekly must be prior-authorized. (5-8-09)

04. Crisis Intervention Service. A maximum of ten (10) hours of crisis support in a community may be authorized per crisis per seven (7) day period. Authorization must follow procedure described above at Subsection 123.04 of these rules. This limitation is in addition to any other PSR service hours within that same time frame. (5-8-09)

05. Skill Training and Community Reintegration. Services are limited to five (5) hours weekly in any combination of individual or group skill training and community reintegration. Up to five (5) additional weekly hours are available with prior authorization. (5-8-09)

06. Pharmacological Management. Pharmacological management services beyond twenty-four (24) encounters per calendar year must be prior authorized by the Department. (5-8-09)

07. Collateral Contact. Collateral contact services beyond six (6) hours per calendar year must be prior authorized by the Department. (5-8-09)

08. Occupational Therapy. Occupational therapy services must be prior authorized by the Department, based on the results of an occupational therapy evaluation completed by an Occupational Therapist licensed in accordance with IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (5-8-09)

09. Place of Service. PSR agency services are to be home and community-based. (5-8-09)

a. PSR agency services must be provided to the participant in his home and community whenever possible. Any other location, including a provider's office or clinic, may be used if the specific place of service is stated in the individualized treatment plan and is necessary to maximize the impact of the service. (5-8-09)

b. PSR agency services may be provided to a participant living in a residential or assisted living

facility if the PSR services are determined by the Department to be appropriate, desired by the resident, and are not the responsibility of the facility or another agency under the Negotiated Service Agreement for residential or assisted living facilities. (5-8-09)

~~*c. Prior to delivering any services in a school based setting, the PSR agency must have a contract with the school or the Infant Toddler program. The PSR agency must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856.* (3-19-07)~~

(BREAK IN CONTINUITY OF SECTIONS)

140. PSYCHOSOCIAL REHABILITATIVE SERVICES (PSR) - PROVIDER REIMBURSEMENT.
Payment for PSR agency services must be in accordance with rates established by the Department. The rate paid for services includes documentation. (5-8-09)

01. Duplication. Payment for services must not duplicate payment made to public or private entities under other program authorities for the same purpose. (3-19-07)

02. Number of Staff Able to Bill. Only one (1) staff member may bill for an assessment, individualized treatment plan, or case review when multiple agency staff are present. (5-8-09)

03. Medication Prescription and Administration. Medication prescription and administration may be billed only by physicians and other medical staff qualified under Title 54, Chapter 18, Idaho Code. (3-19-07)

04. Recoupment. Billing for services and receiving reimbursement for services that were not rendered or failure to comply with these rules must be cause for recoupment of payments for services, sanctions, or both. (3-19-07)

05. Access to Information. Upon request, the provider must provide the Department with access to all information required to review compliance with these rules. Failure by the provider to comply with such a request must result in termination of the Medicaid PSR Provider Agreement. (3-19-07)

06. Evaluations and Tests. Evaluations and tests are a reimbursable service if provided in accordance with the requirements in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." (5-8-09)

07. Psychiatric or Medical Inpatient Stays. Community reintegration services may be provided during the last thirty (30) days of inpatient stay or if the inpatient stay is not expected to last longer than thirty (30) days, when not duplicating those services included in the responsibilities of the inpatient facility. Treatment services are the responsibility of the facility. (5-8-09)

~~***08. Reimbursement for Services Provided in a School**. PSR Services provided by a PSR agency in a school-based setting, must be billed by the school district, charter school, or the Idaho Infant Toddler program.* (3-19-07)~~

(BREAK IN CONTINUITY OF SECTIONS)

508. BEHAVIORAL HEALTH PRIOR AUTHORIZATIONS - DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. (3-19-07)

01. Adult. A person who is eighteen (18) years of age or older~~ *or an ISSH Waiver participant*~~. ~~(3-19-07)~~( )

02. **Assessment**. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)

03. **Clinical Review**. A process of professional review that validates the need for continued services. (3-19-07)

04. **Community Crisis Support**. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)

05. **Concurrent Review**. A clinical review to determine the need for continued prior authorization of services. (3-19-07)

06. **Exception Review**. A clinical review of a plan that falls outside the established standards. (3-19-07)

07. **Interdisciplinary Team**. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)

08. **Level of Support**. An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)

09. **Person-Centered Planning Process**. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-19-07)

10. **Person-Centered Planning Team**. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)

11. **Plan Developer**. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)

12. **Plan Monitor**. A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)

13. **Plan Monitor Summary**. A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews referred to in Subsection 513.06 of these rules. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns. (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. SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget. (3-19-07)

25. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

511. INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY - COVERAGE AND LIMITATIONS. The scope of these rules defines prior authorization for the following Medicaid behavioral health services for adults: (3-19-07)

01. DD~~/ISSH~~ Waiver Services. DD~~/ISSH~~ Waiver services as described in Sections 700 through 719 of these rules; and ~~(3-19-07)~~( )

02. Developmental Disability Agency Services. Developmental Disability Agency services as described in Sections 650 through 660 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies"; and (3-19-07)

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. (3-19-07)

512. BEHAVIOR HEALTH 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 ~~and ISSH~~ 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: ~~*(3-19-07)*~~( )

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. (3-19-07)

04. SIB-R. The results of the SIB-R are used to determine the level of support for the participant. A current SIB-R assessment must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. (3-19-07)

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. BEHAVIOR HEALTH PRIOR AUTHORIZATION - PLAN OF SERVICE.
In collaboration with the participant, the Department must assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. (3-19-07)

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-19-07)

02. Plan Development. The plan must be developed with the participant. With the participant's consent, the person-centered planning team 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. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. (3-19-07)

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 provided outside of a Development Disabilities Agency (DDA). (4-2-08)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services if there are multiple plans of service. Duplicate services will not be authorized. (3-19-07)

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The

plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-19-07)

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed; (3-19-07)

b. Contact with service providers to identify barriers to service provision; (3-19-07)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-19-07)

d. Review of provider status reviews and complete a plan monitor summary after the six (6) month review and for annual plan development. (3-19-07)

e. Immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Regional Medicaid Services (RMS), the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. (3-19-07)

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.11 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: (3-19-07)

a. The status of supports and services to identify progress; (3-19-07)

b. Maintenance; or (3-19-07)

c. Delay or prevention of regression. (3-19-07)

07. Plan Monitor Summary. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status review. (3-19-07)

08. 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)

09. Negotiation for the Plan of Service. If ~~*T*~~the services requested on the plan of service ~~*must be individualized with the participant if the requested services*~~ fall outside the individualized budget or do not reflect the assessed needs of the participant, the plan developer and the participant will have the opportunity to negotiate the plan of service with the Department's care manager. ~~*When the plan of service cannot be negotiated by the assessor, the plan developer, and the participant, it will be referred by the assessor to the Department's care manager for additional evaluation.*~~ Services will not be paid for unless they are authorized on the plan of service.

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

10. Informed Consent. Unless the participant has a guardian with appropriate authority, the participant must make decisions regarding the type and amount of services required. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If not, the plan or amendment must be referred to the Bureau of Care Management's Medicaid Consumer Relations Specialist to negotiate a resolution with members of the planning team. (3-19-07)

11. Provider Implementation Plan. Each provider of Medicaid services, subject to prior authorization, must develop an implementation plan that identifies specific objectives that demonstrate how the provider will assist the participant to meet the participant's goals and needs identified in the plan of service. (3-19-07)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-19-07)

i. Specialized medical equipment; (3-19-07)

ii. Home delivered meals; (3-19-07)

iii. Environmental modifications; (3-19-07)

iv. Non-medical transportation; (3-19-07)

v. Personal emergency response systems (PERS); (3-19-07)

vi. Respite care; and (3-19-07)

vii. Chore services. (3-19-07)

b. Time for Completion. The implementation plan must be completed within fourteen (14) days after the initial provision of service, and revised whenever participant needs change. (3-19-07)

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)

12. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. (3-19-07)

13. Community Crisis Supports. Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any consecutive five (5) day period. (3-19-07)

a. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-19-07)

b. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-19-07)

c. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within three (3) business days. (3-19-07)

14. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. (3-19-07)

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: (3-19-07)

i. Notify the providers who appear on the plan of service of the annual review date. (3-19-07)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.14.d of these rules. (3-19-07)

iii. Convene the person-centered planning team to develop a new plan of service. (3-19-07)

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service must be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. (3-19-07)

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. (3-19-07)

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 513.12 of these rules. (3-19-07)

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. (3-19-07)

f. Annual Assessment Results. An annual assessment must be completed in accordance with Section 512 of these rules. (3-19-07)

15. Reconsiderations, Complaints, and Administrative Appeals. (3-19-07)

a. Reconsideration. Participants with developmental disabilities who are adversely affected by a Department decision regarding program eligibility and authorization of services under these rules may request a reconsideration within twenty-eight (28) days from the date the decision was mailed. The reconsideration must be performed by an interdisciplinary team as determined by the Department with at least one (1) individual who was not involved in the original decision. The reviewers must consider all information and must issue a written decision within fifteen (15) days of receipt of the request. (3-19-07)

b. Complaints. 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, Bureau of Care Management. (3-19-07)

c. Administrative Appeals. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (3-19-07)

514. BEHAVIORAL HEALTH PRIOR AUTHORIZATION - PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. (3-19-07)

01. Methodology for Developing Participant Budget Prior to October 1, 2006. The participant budget is developed using the following methodology: (3-19-07)

a. Evaluate the past three (3) years of Medicaid expenditures from the participant's profile, excluding physician, pharmacy, and institutional services; (3-19-07)

b. Review all assessment information identified in Section 512 of these rules; (3-19-07)

c. Identify the level of support derived from the most current SIB-R. The level of support is a combination of the individual's functional abilities and maladaptive behavior as determined by the SIB-R. Six (6) broad levels of support have been identified on a scale from zero to one hundred (0 - 100) (see Table 514.01.c.). There

are six (6) levels of support, each corresponding to a support score range.

TABLE 514.01.c. - LEVEL OF SUPPORT	
Support Score Range	**Level of Support**
1-24	Pervasive
25-39	Extensive
40-54	Frequent
55-69	Limited
70-84	Intermittent
85-100	Infrequent

(3-19-07)

d. Correlate the level of support identified by the SIB-R to a budget range derived from the expenditures of individuals at the same level of support across the adult DD population. This correlation will occur annually prior to the development to the plan of service; (3-19-07)

02. Negotiating an Appropriate Participant Budget Prior to October 1, 2006. The assessor, the participant, and the plan developer must use all the information from Subsections 514.01.a. through 514.01.d. of these rules to negotiate an appropriate budget that will support the participant's identified needs. (3-19-07)

03. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD ~~*and ISSH*~~ 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, medical needs, and other individual factors 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. ~~*(3-19-07)*~~(____)

a. During the implementation phase of using the new individualized budget-setting methodology, the budget calculation will include reviewing the participant's previous year's budget. When the calculated budget is less than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the calculated budget amount. When the calculated budget is greater than five percent (5%) above or below the previous year's budget, the participant's set budget amount is the previous year's budget amount. The Department will collect information on discrepancies between the calculated budget and the previous year's budget as part of the ongoing assessment and improvement process of the budget-setting methodology. (3-19-07)

b. The Department notifies each participant of his set budget amount. The notification will include how the participant may request reconsideration of the set budget amount (3-19-07).

c. 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 individualized needs and it is demonstrated that these additional needs cannot be supported by the current budget. (3-19-07)

04. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant's independence increases and he is less dependent on supports, he must transition to less intense supports. (3-19-07)

a. High support is for those participants who require twenty-four (24) hour per day supports and

supervision and have an SIB-R Support Level of Pervasive, Extensive, or Frequent. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (3-19-07)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: (3-19-07)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-19-07)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-19-07)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-19-07)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/MR with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-19-07)

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except when all of the following conditions are met: (3-19-07)

i. The participant is eligible to receive the high support daily rate; (3-19-07)

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

653. DDA SERVICES - COVERAGE REQUIREMENTS AND LIMITATIONS.

01. Requirement for Plan of Service and Prior Authorization. (3-19-07)

a. All therapy services for children must be identified on the Individual Program Plan developed by the developmental disabilities agency (DDA) as described in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. All therapy services for adults with developmental disabilities ~~*and ISSH waiver participants*~~ must be identified on the plan of service and prior authorized as described in Sections 507 through 520 of these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." ~~*(3-19-07)*~~( )

02. Assessment and Diagnostic Services. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation or diagnostic services provided in any calendar year. Additional hours may be approved for a child through the month of his twenty-first birthday with approval from EPSDT staff in the Division of Medicaid. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies": (3-19-07)

a. Comprehensive Developmental Assessment; (3-19-07)

b. Comprehensive Intensive Behavioral Intervention (IBI) Assessment. Before conducting the comprehensive IBI assessment, the DDA must receive prior authorization from the Department. The time required to complete this assessment is included in the thirty-six (36) month IBI limitation but does not count against the twelve (12) hour limitation described in this subsection; (3-19-07)

c. Occupational Therapy Assessment (3-19-07)

d. Physical Therapy Assessment; (3-19-07)

e. Speech and Language Assessment; (3-19-07)

f. Medical/Social History; and (3-19-07)

g. Psychological Assessment. Includes psychological testing and psychiatric diagnostic interview. (3-19-07)

03. Therapy Services. Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in IDAPA 16.04.11, "Developmental Disabilities Agencies." The following therapy services are reimbursable when provided in accordance with these rules and IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

a. Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Participants living in a certified family home must not receive home-based developmental therapy in a certified family home. Developmental therapy includes individual developmental therapy and group developmental therapy. (3-19-07)

b. Psychotherapy Services. Psychotherapy services, alone or in combination with supportive counseling, are limited to a maximum of forty-five (45) hours in a calendar year, and include: (3-19-07)

i. Individual psychotherapy; (3-19-07)

ii. Group psychotherapy; and (3-19-07)

iii. Family-centered psychotherapy which must include the participant and one (1) other family member at any given time. (3-19-07)

c. Supportive Counseling. Supportive counseling must only be delivered on an individualized, one to-one basis. Supportive counseling, alone or in combination with psychotherapy services, is limited to a maximum of forty-five (45) hours in a calendar year. (3-19-07)

d. Speech-Language Pathology Services. Speech-language pathology services include individual or

group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

e. Physical Therapy Services. Physical therapy services include individual or group therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

f. Occupational Therapy Services. Occupational therapy services include individual occupational therapy and group occupational therapy. These services are limited in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 730 through 739. (4-2-08)

g. Intensive Behavioral Intervention (IBI). IBI is limited to a lifetime limit of thirty six (36) months. (3-19-07)

i. The DDA must receive prior authorization from the Department prior to delivering IBI services. (3-19-07)

ii. IBI must only be delivered on an individualized, one-to-one basis. (3-19-07)

h. Intensive Behavioral Intervention (IBI) Consultation. IBI consultation is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (3-19-07)

i. Collateral Contact. Collateral contact is consultation or treatment direction about the participant to a significant other in the participant's life and may be conducted face-to-face or by telephone contact. Collateral contact for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings, even when the parent is present, is not reimbursable. (3-19-07)

j. Pharmacological Management. Pharmacological management is consultation for the purpose of prescribing, monitoring, or administering medications. These consultations must be provided by a physician or other practitioner of the healing arts in direct face-to-face contact with the participant and be provided in accordance with the plan of service with the type, amount, frequency and duration of the service specified. The telephoning of prescriptions to the pharmacy is not a billable service. (3-19-07)

04. Excluded Services. The following services are excluded for Medicaid payments: (3-19-07)

a. Vocational services; (3-19-07)

b. Educational services; and (3-19-07)

c. Recreational services. (3-19-07)

05. Limitations on DDA Services. Therapy services may not exceed the limitations as specified below. (3-19-07)

a. The combination of therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules must not exceed twenty-two (22) hours per week. (1-1-09)T

b. Therapy services listed in Subsections 653.03.a. through 653.03.g. of these rules provided in combination with Community Supported Employment services under Subsection 703.04 of these rules must not exceed forty (40) hours per week. (3-19-07)

c. When a HCBS waiver participant under Sections 700 through 719 of these rules receives Adult Day Care as provided in Subsection 703.12 of these rules, the combination of Adult Day Care, Developmental Therapy and Occupational therapy must not exceed thirty (30) hours per week. (3-19-07)

d. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid

program. No therapy services will be reimbursed during periods when the participant is being transported to and from the agency. (3-19-07)

~~*e. Prior to delivering any services in a school-based setting, the DDA must have a contract with the school or the Infant Toddler program. The DDA must not bill Medicaid or the Medicaid participant for these contracted services. Only the school district, charter school, or the Idaho Infant Toddler program may bill Medicaid for these contracted services when provided in accordance with IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Sections 850 through 856.* (3-19-07)~~

(BREAK IN CONTINUITY OF SECTIONS)

700. INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES~~*/ISSH*~~ WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible 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 a participant to be eligible the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/MR.
~~*(3-19-07)*~~( )

701. (RESERVED).

702. DD~~*/ISSH*~~ 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, "Rules Governing 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: ~~*(3-19-07)*~~( )

01. Age of Participants. DD waiver participants must be eighteen (18) years of age or older. ~~*ISSH waiver participants must be fifteen (15) years of age through the month of their eighteenth birthday.*~~
~~*(3-19-07)*~~( )

02. Eligibility Determinations. The Department must determine that: (3-19-07)

a. The participant would qualify for ICF/MR 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/MR care and other medical costs. (7-1-06)

d. Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (3-19-07)

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 ~~*ISSH and*~~ DD may elect to not utilize waiver services but may choose admission to an ICF/MR. ~~*(3-19-07)*~~( )

04. Processing Applications. The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," as if the application was for admission to an ICF/MR, 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, "Rules Governing 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 ~~*and after June 30th for the ISSH waiver*~~ of each new waiver year. ~~*(3-19-07)*~~(____)

703. DD~~/ISSH~~ WAIVER SERVICES - COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services which consist of an integrated array of individually-tailored services and supports furnished to eligible participants which are designed to assist them to reside successfully in their own homes, with their families, or alternate family homes. The services and supports that may be furnished consist of the following: (3-19-07)

a. Habilitation services aimed at assisting the individual to acquire, retain or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-19-07)

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-19-07)

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-19-07)

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; (3-19-07)

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

necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities which are merely diversional or recreational in nature); (3-19-07)

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; (3-19-07)

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. (3-19-07)

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on his own behalf. (3-19-07)

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self direction, money management, socialization, mobility and other therapeutic programs. (3-19-07)

02. Chore Services. Chore services which are heavy household maintenance and minor home repairs necessary to maintain the functional use of the home and to provide a clean, sanitary and safe environment. Chore activities include washing windows; moving heavy furniture and shoveling snow to provide safe access inside and outside the home; chopping wood when wood is the participant's primary source of heat; and tacking down loose rugs and flooring. 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, caretaker, landlord, community volunteer/agency or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to 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. (3-19-07)

03. Respite. Respite care services are those services provided on a short term basis because of the absence of persons normally providing non-paid care. Respite care services provided under this waiver will not include room and board payments. Respite care services are limited to participants who reside with non-paid caregivers. (3-19-07)

04. Supported Employment. Supported employment which is 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; and who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. (3-19-07)

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 will 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 IDEA. (3-19-07)

b. Federal Financial Participation (FFP) will not 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 employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-19-07)

05. Transportation. Transportation services which are services offered in order to enable waiver participants to gain access to waiver and other community services and resources required by the plan of service. This service is offered in addition to medical transportation required under 42 CFR 440.431.53 and transportation services

offered under the State Plan, defined at 42 CFR 440.170(a), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge or public transit providers will be utilized. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations which are those interior or exterior physical adaptations to the home, required by the waiver participant's plan of service, which are necessary to ensure the health, welfare, safety of the individual, or which enable the individual to function with greater independence in the home and without which, the waiver participant would require institutionalization. Such adaptations may include the installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which 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 which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. All services must be provided in accordance with applicable State or local building codes. Permanent environmental modifications are limited to modifications to a home rented or owned by the participant or the participant's family when the home is the participant's principal residence. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

07. Specialized Equipment and Supplies. Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the plan of service which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. They also include items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds must be in addition to any medical equipment and supplies furnished under the State Plan and must exclude those items which are not of direct medical or remedial benefit to the participant. All items must meet applicable standards of manufacture, design and installation. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who rent or own their home, who are alone for significant parts of the day, have no regular caretaker for extended periods of time and who would otherwise require extensive routine supervision. (3-19-07)

09. Home Delivered Meals. Home delivered meals which are designed to promote adequate wavier participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who rent or own their own home, who are alone for significant parts of the day and have no regular caretaker for extended periods of time. (3-19-07)

10. Skilled Nursing. Nursing services are those intermittent nursing services or private duty nursing services which provide individual and continuous care listed in the plan of service which are within the scope of the Nurse Practice Act and are provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. (3-19-07)

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services which provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. (3-19-07)

12. Adult Day Care. Adult Day Care is a supervised, structured day program, outside the home of the participant that offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. These activities need to be identified on the plan of service. Adult Day Care can not exceed thirty (30) hours per week either alone or in combination with developmental therapy, occupational therapy, or IBI. (3-19-07)

a. Services provided in a facility must meet the building and health standards identified in IDAPA

16.04.11, "Developmental Disabilities Agencies." (3-19-07)

b. Services provided in a home must meet the standards of home certification identified in IDAPA 16.03.19, "Rules Governing Certified Family Home," and health standards identified in IDAPA 16.04.11, "Developmental Disabilities Agencies." (3-19-07)

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 the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: (3-19-07)

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and (3-19-07)

b. Licensed Intermediate Care Facility for persons with Mental Retardation (ICF/MR); and (3-19-07)

c. Residential Care or Assisted Living Facility. (3-19-07)

d. Additional limitations to specific services are listed under that service definition. (3-19-07)

704. DD~~/ISSH~~ 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 which 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. DD~~/SSH~~ 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. Residential habilitation services must be provided by an agency that is certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a Residential Habilitation Agency. The Residential Habilitation Agency provides oversight, training, and quality assurance to the certified family home provider. 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: (3-19-07)

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 an plan of service; (3-19-07)

iii. Have current CPR and First Aid certifications; (3-19-07)

iv. Be free from communicable diseases; (3-19-07)

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. Staff previously trained on assistance with medications by a licensed nurse but who have not completed this course must meet this requirement by July 1, 2007. (3-19-07)

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-19-07)

b. All skill training for direct service staff must be provided by a Qualified Mental Retardation Professional (QMRP) who has demonstrated experience in writing skill training programs. (3-19-07)

c. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-19-07)

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 or affiliation with the residential habilitation agency and include at a minimum: (3-19-07)

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. When residential habilitation services are provided in the provider's home, the provider's home must meet the requirements in IDAPA 16.03.19, "Rules Governing Certified Family Homes." Non-compliance with the certification process is cause for termination of the provider's provider agreement. (3-19-07)

02. 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 must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background

Checks." (4-2-08)

03. Respite. Providers of respite care services must meet the following minimum qualifications: (3-19-07)

a. Meet the qualifications prescribed for the type of services to be rendered or must be an individual selected by the waiver participant, the family or his guardian; (3-19-07)

b. Have received care giving instructions in the needs of the person who will be provided the service; (3-19-07)

c. Demonstrate the ability to provide services according to an plan of service; (3-19-07)

d. Have good communication and interpersonal skills and the ability to deal effectively, assertively and cooperatively with a variety of people; (3-19-07)

e. Be willing to accept training and supervision by a provider agency or the primary caregiver of services; and (3-19-07)

f. Be free of communicable diseases. (3-19-07)

g. 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." (4-2-08)

04. Supported Employment. Supported Employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

05. Transportation. Providers of transportation services must: (3-19-07)

a. Possess a valid driver's license; and (3-19-07)

b. Possess valid vehicle insurance. (3-19-07)

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations services must: (3-19-07)

a. Be done under a permit, if required; and (3-19-07)

b. Demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing and building codes. (3-19-07)

07. Specialized Equipment and Supplies. Specialized Equipment and Supplies purchased under this service must: (3-19-07)

a. Meet Underwriter's Laboratory, FDA, or Federal Communication Commission standards where applicable; and (3-19-07)

b. Be obtained or provided by authorized dealers of the specific product where applicable. This may include medical supply businesses or organizations that specialize in the design of the equipment. (3-19-07)

08. Personal Emergency Response System. Personal Emergency Response Systems (PERS) must demonstrate that the devices installed in waiver participants' homes meet Federal Communications Standards or Underwriter's Laboratory standards or equivalent standards. (3-19-07)

09. Home Delivered Meals. Services of Home Delivered Meals under this section may only be provided by an agency capable of supervising the direct service and must: (3-19-07)

a. Provide assurances that each meal meets one third (1/3) of the Recommended Dietary Allowance as defined by the Food and Nutrition Board of National Research Council or meet physician ordered individualized therapeutic diet requirement; (3-19-07)

b. Must provide assurances that the meals are delivered on time and demonstrate the ability to deliver meals at a minimum of three (3) days per week; (3-19-07)

c. Maintain documentation reflecting the meals delivered are nutritionally balanced and made from the highest U.S.D.A. Grade for each specific food served; (3-19-07)

d. Provide documentation of current driver's license for each driver; and (3-19-07)

e. Must be inspected and licensed as a food establishment by the District Health Department. (3-19-07)

10. Skilled Nursing. Nursing service providers must provide documentation of current Idaho licensure as a licensed professional nurse (RN) or licensed practical nurse (LPN) in good standing. (3-19-07)

11. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: (3-19-07)

a. Work for a provider agency capable of supervising the direct service or 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 (3-19-07)

b. Must 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 Mental Retardation Professional (QMRP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Rules Governing 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 IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

12. Adult Day Care. Providers of adult day care services must be employed by or be affiliated with the residential habilitation agency that provides program coordination for the participant if the service is provided in a certified family home other than the participant's primary residence, be capable of supervising direct services, provide services as identified on the plan of service, provide care and supervision identified on the participant's residential habilitation plan, and must meet the following minimum qualifications: (3-19-07)

a. Demonstrate the ability to communicate and deal effectively, assertively, and cooperatively with a variety of people; (3-19-07)

b. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to the plan of service; (3-19-07)

c. Be free from communicable disease; (3-19-07)

d. Adult day care 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"; (4-2-08)

e. Demonstrate knowledge of infection control methods; and (3-19-07)

f. Agree to practice confidentiality in handling situations that involve waiver participants. (3-19-07)

13. Service Supervision. The plan of service which includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-19-07)

706. DD~~/ISSH~~ 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)

(BREAK IN CONTINUITY OF SECTIONS)

723. SERVICE COORDINATION -- ELIGIBILITY -- INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
An individual is eligible to receive service coordination if he meets the following requirements in Subsection 723.01 through 723.03 of this rule. (5-8-09)

01. Age. An adult eighteen (18) years of age or older~~, or adolescent fifteen to eighteen (15-18) years of age who is authorized to receive services through the Idaho State School and Hospital (ISSH) waiver. (5-8-09)~~( )

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 mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (5-8-09)

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

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated. (5-8-09)

03. Need Assistance. Requires and chooses assistance to access services and supports necessary to maintain his independence in the community. (5-8-09)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-0907

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-203(g), 56-203(i), and 56-250 through 56-257, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than Wednesday, October 21, 2009.

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

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

The Division of Medicaid is proposing to change these rules to allow for the development of a uniform, statewide consumer-directed services model for all Medicaid programs. This will allow Medicaid's consumer-directed programs to use the same service model. The rule changes proposed in this chapter regarding the removal of references to the fiscal intermediary services under the Home and Community Based Services Waiver for the Aged and Disabled (HCBS A&D) will align with changes being proposed under companion Docket No. 16-0313-0901.

The following is a summary of the proposed changes:

1. The current fiscal intermediary (FI) rules for the HCBS A&D waiver are being removed and replaced with a reference to the self-direction rules found in IDAPA 16.03.13, “Consumer-Directed Services.” FI is a service option available under the A&D waiver and allows participant direction of personal care services.

2. References to requirements for providers of FI services (e.g., criminal history and agency training) are being removed. The agency training and criminal history requirements that pertain to personal assistance agencies are being clarified.

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

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

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted. The negotiated rulemaking was informal. No notice of Intent to Promulgate Rules was published.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Susan Scheuerer at (208) 287-1156.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before Wednesday, October 28, 2009.

DATED this 2nd day of September, 2009.

Tamara Prisock
DHW - Administrative Procedures Section
450 W. State Street - 10th Floor
P.O. Box 83720, Boise, ID 83720-0036
(208) 334-5564 phone; (208) 334-6558 fax
dhwrules@dhw.idaho.gov e-mail

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-0907

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

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

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

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

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

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

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

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

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

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

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

a. "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)

b. "Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)" means an entity as defined in Subsection 011.29 in this rule. (3-19-07)

c. "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)

d. 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)

e. "Urban Hospital-Based Nursing Facilities" means hospital-based nursing facilities located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. (3-19-07)

~~***08. Fiscal Intermediary Agency**. An entity that provides services that allow the participant receiving***

~~*personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing, training, and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered.* *(5-8-09)*~~

0~~9~~8. **Fiscal Year**. An accounting period that consists of twelve (12) consecutive months. (3-19-07)

~~10~~09. **Forced Sale**. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner which requires ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. (3-19-07)

1~~1~~0. **Funded Depreciation**. Amounts deposited or held which represent recognized depreciation. (3-19-07)

1~~2~~1. **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)

1~~3~~2. **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)

1~~4~~3. **Healthy Connections**. The primary care case management model of managed care under Idaho Medicaid. (3-19-07)

1~~5~~4. **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)

1~~6~~5. **ICF/MR Living Unit**. The physical structure that an ICF/MR uses to house patients. (3-19-07)

1~~7~~6. **Improvements**. Improvements to assets which increase their utility or alter their use. (3-19-07)

1~~8~~7. **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)

19~~8~~. **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)

~~20~~19. **Inflation Factor**. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by Data Resources, Inc. (DRI), or its successor. If subsequent to the effective date of these rules, Data Resources, Inc., or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with DRI or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. (3-19-07)

2~~1~~0. **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)

2~~2~~1. **Inspection of Care Team (IOCT)**. An interdisciplinary team which provides inspection of care in intermediate care facilities for the mentally retarded approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: (3-19-07)

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

b. One (1) qualified mental retardation professional; 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)

2~~3~~2. **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)

2~~4~~3. **Interest**. The cost incurred for the use of borrowed funds. (3-19-07)

2~~5~~4. **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)

2~~6~~5. **Interest on Working Capital**. The costs incurred for borrowing funds which will be used for "working capital" purposes. These costs are reported under administrative costs. (3-19-07)

2~~7~~6. **Interest Rate Limitation**. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/MR 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)

2~~8~~7. **Interim Reimbursement Rate (IRR)**. A rate paid for each Medicaid patient day which is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. (3-19-07)

2~~9~~8. **Intermediary**. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. (3-19-07)

~~30~~29. **Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)**. An entity licensed as an ICF/MR and federally certified to provide care to Medicaid and Medicare participants with developmental

disabilities. (3-19-07)

3~~1~~0. **Keyman Insurance**. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

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*~~ financial management services in accordance with ~~*Section 329 of these rules*~~ IDAPA 16.03.13, "Consumer-Directed Services." 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 professional nurse (RN) or, where applicable, a QMRP 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 RMS; (3-19-07)

h. Collecting any participant contribution due; (5-8-09)

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

j. Making referrals for PCS-eligible participants for service coordination as described in Sections 720 through 779 of these rules when a need for the service is identified. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

321. AGED OR 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 which outlines all services including, but not limited to, personal assistance services and instrumental activities of daily living (IADL), required to maintain the individual in his home and community. The plan is initially developed by the RMS or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RMS and all Medicaid reimbursable services must be contained in the plan. (3-19-07)

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 which 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)***~~

0~~6~~4. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

323. AGED OR DISABLED WAIVER SERVICES - PARTICIPANT ELIGIBILITY DETERMINATION.
Waiver eligibility will be determined by the RMS. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." In addition, waiver participants must meet the following requirements. (3-19-07)

01. Requirements for Determining Participant Eligibility. The RMS must determine that: (3-19-07)

a. The participant would qualify for nursing facility level of care under Section~~s 222 and 223~~ 322 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. This determination must be made by the RMS. Prior to any denial of services on this basis, the Department must verify that services to correct the concerns of the team are not available. (3-19-07)

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 RMS 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. (3-19-07)

02. Admission to a Nursing Facility. A participant who is determined by the RMS to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a nursing facility.

(3-19-07)

03. Redetermination Process. Case Redetermination will be conducted by the RMS 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. (3-19-07)

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED OR DISABLED WAIVER SERVICES - COVERAGE AND LIMITATIONS.

01. Adult Day Care. Adult day care is a supervised, structured day program, outside the home of the participant, that may offer one (1) or more of a variety of social, recreational, health activities, supervision for safety, and assistance with activities of daily living. (3-19-07)

02. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho," that includes: (3-19-07)

a. Medication management; (3-19-07)

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

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

d. Housekeeping; (3-19-07)

e. Laundry; (3-19-07)

f. Transportation; (3-19-07)

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

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

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

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

k. A written individual service plan must be negotiated between the participant or his legal representative, and a facility representative. (3-19-07)

03. Assistive Technology. Assistive technology is any item, piece of equipment, or product system beyond the scope of the Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. (3-19-07)

04. Assisted Transportation. Individual assistance with non-medical transportation services, including escort to a person who has difficulties (physical or cognitive) using regular vehicular transportation. Such services are specified in the plan for services in order to enable waiver participants to gain access to waiver and other community services and resources. (3-19-07)

a. Assisted transportation service is offered in addition to medical transportation required in IDAPA

16.03.09, "Medicaid Basic Plan Benefits," Sections 860 through 876, and will not replace it. (3-19-07)

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. ( )

a. Attendant care services are those services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Services may occur in the participant's home, community, work, or school, or in recreational settings.~~*(3-30-07)*~~( )

~~***a.*** *To utilize the services of a Personal Assistance Agency acting as a fiscal intermediary, the participant family, or legal representative must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized.*~~ ~~*(3-19-07)*~~

b. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (3-19-07)

06. Chore Services. Chore services include the services provided in Subsection 326.06.a. and 326.06.b. of this rule: (3-19-07)

a. Intermittent Assistance may include the following. (3-19-07)

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 their home. (3-19-07)

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, caretaker, landlord, community volunteer, agency, or third party payer is willing to or is responsible for their provision. (3-19-07)

d. In the case of rental property, the responsibility of the landlord, pursuant to 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. (3-19-07)

07. Adult Companion. In-home services to insure 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 may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. However, the major responsibility is to provide companionship and be there in case they are needed. (3-19-07)

08. Consultation. Consultation services are services to a participant or family member. Services provided by a PAA 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/family. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (3-19-07)

09. Home Delivered Meals. Meals which are designed to promote adequate participant nutrition through the provision and home delivery of one (1) to two (2) meals per day. Home delivered meals are limited to participants who: (3-19-07)

a. Rent or own their own home; (3-19-07)

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

c. Have no regular caretaker for extended periods of time; and (3-19-07)

d. Are unable to prepare a balanced meal. (3-19-07)

10. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (3-19-07)

11. Home Modifications. 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. Such adaptations may include: (3-19-07)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but will exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-19-07)

b. Permanent environmental modifications are limited to modifications to a home owned by the participant or the participant's family and the home is the participant's principal residence. (3-19-07)

c. Portable or Non-Stationary Modifications. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned to the Department. (3-19-07)

12. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. PERS are limited to participants who: (3-19-07)

a. Rent or own their home, or live with unpaid relatives; (3-19-07)

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

c. Have no caretaker for extended periods of time; and (3-19-07)

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

13. Psychiatric Consultation. Psychiatric Consultation is 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 to the direct service provider or participant's family related to the needs of a participant. These services also provide emergency intervention involving the direct support of the participant in crisis. (3-19-07)

14. Respite Care. Occasional breaks from care giving responsibilities to non-paid care givers. The care giver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other waiver services which are duplicative in nature. Respite care services provided under this waiver will not include room and board payments. (3-19-07)

15. Service Coordination. Service coordination includes all of the activities contained in Section 727 of these rules. Such services are designed to foster independence of the participant, and will be time limited. (3-19-07)

a. All services will be provided in accordance with an individual service plan. All services will be incorporated into the Individual Service plan and authorized by the RMS. (3-19-07)

b. The service coordinator must notify the RMS, the Personal Assistance Agency, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (3-19-07)

16. Skilled Nursing Services. Intermittent or continuous oversight, training, or skilled care which is within the scope of the Nurse Practice Act and as such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. Nursing services may include but are not limited to: (3-19-07)

a. The insertion and maintenance of nasogastric tubes and the monitoring or installation of feeding material; (3-19-07)

b. The maintenance of volume ventilators including associated tracheotomy care, tracheotomy, and oral pharyngeal suctioning. (3-19-07)

c. Maintenance and monitoring of IV fluids or nutritional supplements which are to be administered on a continuous or daily basis; (3-19-07)

d. Injections; (3-19-07)

e. Blood glucose monitoring; and (3-19-07)

f. Blood pressure monitoring. (3-19-07)

17. Habilitation. 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 alternate family homes. (3-30-07)

a. Residential habilitation services assist the individual to acquire, retain, or improve his ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: (3-30-07)

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 his community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in 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)

b. Day rehabilitation 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 rehabilitation services will focus on enabling the participant to attain or maintain his or her 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 rehabilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. (4-2-08)

18. 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 by RMS 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. (3-30-07)

b. Federal Financial Participation (FFP) can not 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 programs, payments that are passed through to beneficiaries of supported employment programs, or payments for vocational training that is not directly related to a waiver participant's supported employment program. (3-30-07)

19. Behavior Consultation or Crisis Management. Behavior consultation or crisis management consists of services that provide direct consultation and clinical evaluation of participants who are currently experiencing, or are 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 include emergency back-up that provides direct support and services to a participant in crisis. (3-30-07)

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED OR DISABLED WAIVER SERVICES - PROCEDURAL REQUIREMENTS.

01. Role of the Regional Medicaid Services. The RMS will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by RMS staff or a contractor. The RMS will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. (3-30-07)

a. Services which are not in the individual service plan approved by the RMS are not eligible for Medicaid payment. (3-19-07)

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 RMS for Medicaid payment is the date that the participant's individual service plan is signed by the participant or his designee. (3-19-07)

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

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

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

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

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the RMS or its contractor. (3-19-07)

04. Individual Service Plan. All waiver services must be authorized by the RMS in the Region where the participant will be residing and services provided based on a written individual service plan. (3-30-07)

a. The initial individual service plan is developed by the RMS or its contractor, based on the UAI, in conjunction with: (3-19-07)

i. The waiver participant (with efforts made by the RMS to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); (3-30-07)

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

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

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

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

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

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

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

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

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

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

d. All services reimbursed under the Aged or Disabled Waiver must be authorized by the RMS prior to the payment of services. (3-19-07)

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the RMS or its contractor. (3-19-07)

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

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

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

ii. The Department's administrative case manager; (3-30-07)

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

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

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

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

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

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

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

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

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

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

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

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

e. The Department's case manager monitors the plan of care and all waiver services. (3-30-07)

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

06. 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 RMS 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. (3-19-07)

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 RMS. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (3-19-07)

c. The individual service plan initiated by the RMS 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 RMS to each individual service provider with a release of information signed by the participant or legal representative. (3-19-07)

07. Provider Responsibility for Notification. The service provider is responsible to notify the RMS, 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. (3-19-07)

08. 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)

~~***09. Requirements for an Fiscal Intermediary (FI)**. Participants of PCS will have one (1) year from the date which services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules.*~~ ~~*(3-19-07)*~~

329. AGED OR 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)*~~

0~~2~~1. ~~***Fiscal Intermediary Services**. An agency that has responsibility for the following:*~~ **Financial Management Co-Employer** The definition, criminal history requirements, provider responsibilities, and provider requirements for a financial management co-employer are found in IDAPA 16.03.13, "Consumer-Directed Services." ~~*(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 make referrals for service coordination for a PCS eligible participant when a need for such services is identified; and~~ ~~(5-8-09)~~

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

0~~3~~2. **Provider Qualifications**. All personal assistance providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants 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 approved Aged and Disabled waiver as approved by CMS. ~~(3-19-07)~~( )

a. A waiver provider can not 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~~ this rule~~s~~, 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," including: (4-2-08)

i. Companion services; (4-2-08)

ii. Chore services; and (4-2-08)

iii. Respite care services. (4-2-08)

0~~4~~3. **Specialized Medical Equipment Provider Qualifications**. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (3-19-07)

0~~5~~4. **Nursing Service Provider Qualifications**. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (3-19-07)

06~~5~~. Psychiatric Consultation Provider Qualifications. Psychiatric Consultation Providers must have: (3-19-07)

a. A master's degree in a behavioral science; (3-19-07)

b. Be licensed in accordance with state law and regulations; or (3-19-07)

c. A bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (4-2-08)

d. Psychiatric consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

07~~6~~. Service Coordination. Service coordinators and service coordination agencies must meet the requirements specified in Section 729 of these rules unless specifically modified by another section of these rules. (3-19-07)

08~~7~~. Consultation Services. 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. (3-19-07)

09~~8~~. Adult Residential Care Providers. Adult Residential Care providers will meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Rules Governing Certified Family Homes," and IDAPA 16.03.22, "Residential Care or Assisted Living Facilities in Idaho." (4-2-08)

~~1~~09. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (3-19-07)

a. Supervising the direct service; (3-19-07)

b. Providing assurance that 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; (3-19-07)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (3-19-07)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (3-19-07)

e. Being inspected and licensed as a food establishment by the district health department. (3-19-07)

1~~1~~0. Personal Emergency Response Systems. Providers must demonstrate that the devices installed in waiver participant's homes meet Federal Communications Standards, Underwriter's Laboratory Standards, or equivalent standards. (3-19-07)

1~~2~~1. Adult Day Care. Facilities that provide adult day care must be maintained in safe and sanitary manner. (3-30-07)

a. Facilities will provide the necessary space and staff to meet the needs of the participants accepted by the provider. Supervision must be provided by the facility as necessary, to assure the safety and comfort of participants served. (3-19-07)

b. Providers who accept participants into their homes for services must maintain the homes in a safe and sanitary manner. Supervision must be provided by the provider as necessary to assure the safety and comfort of participants served. (3-30-07)

c. Adult day care 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." (4-2-08)

1~~3~~2. **Assistive Technology**. All items must meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need. (3-19-07)

1~~4~~3. **Assisted Transportation Services**. See Subsection 329.0~~3~~2 of this rule for provider qualifications. ~~*(3-19-07)*~~( )

1~~5~~4. **Attendant Care**. See Subsection 329.0~~3~~2 of this rule for provider qualifications. 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." ~~*(4-2-08)*~~( )

1~~6~~5. **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." (4-2-08)

1~~7~~6. **Home Modifications**. 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. (3-19-07)

1~~8~~7. **Residential Habilitation Provider Qualifications**. Residential habilitation services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in their own home must be certified by the Department as a certified family home and must be affiliated with a residential habilitation agency. The residential habilitation agency provides oversight, training, and quality assurance to the certified family home provider. 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: (3-30-07)

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 care; (3-30-07)

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

iv. Be free from communicable diseases; (3-30-07)

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 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;" (4-2-08)

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

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury

training course approved by the Department, and training specific to the needs of the participant. Skill training may be provided by a Program Coordinator who has demonstrated experience in writing skill training programs, if no agency is available in their geographic area as outlined in Subsection 329.1~~8~~7.c. of this rule. ~~(3-30-07)~~( )

c. Residential habilitation providers who are unable to be employed by an agency because one is not available in their geographic area, must receive program development, implementation and oversight of service delivery services by a program coordinator who has a valid service coordination provider agreement with the Department and who has taken a traumatic brain injury training course approved by the Department. (3-30-07)

d. Prior to delivering services to a participant, direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-30-07)

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)

e. Additional training requirements must be completed within six (6) months of employment or affiliation with the residential habilitation agency and include at a minimum: (3-30-07)

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)

f. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed; and (3-30-07)

g. When residential habilitation services are provided in the provider's home, the provider must meet the requirements in IDAPA 16.03.19, “Rules Governing Certified Family Homes.” Non-compliance with the

certification process is cause for termination of the provider agreement or contract. (3-30-07)

1~~9~~8. Day Rehabilitation Provider Qualifications. Providers of day rehabilitation 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 rehabilitation 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." (4-2-08)

~~20~~19. Supported Employment Service Providers. Supported employment services must be provided by an agency capable of supervising the direct service and be accredited by the Commission on Accreditation of Rehabilitation Facilities; or other comparable standards; or meet State requirements to be a State-approved provider, and have taken a traumatic brain injury training course approved by the Department. 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." (4-2-08)

2~~1~~0. Behavior Consultation or Crisis Management Service Providers. Behavior consultation or crisis management providers must meet the following: (3-30-07)

a. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, or a closely related course of study; (3-30-07)

b. Be a licensed pharmacist; or (3-30-07)

c. Work for a provider agency capable of supervising the direct service or work under the direct supervision of a licensed psychologist or Ph.D., with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and (3-30-07)

d. Take a traumatic brain injury training course approved by the Department. (3-30-07)

e. Emergency back-up providers must also meet the minimum provider qualifications under residential habilitation services. (3-30-07)

f. Behavior consultation or crisis management 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." (4-2-08)