Dear Senators LODGE, Broadsword, Bock, and
Representatives MCGEACHIN, Bilbao, Rusche:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Department of Health and Welfare - :

IDAPA 16.02.02 - Rules Pertaining To The Idaho Emergency Medical Services (EMS) Physician Commission (Docket No. 16-0202-1201);

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1203);

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1204);

IDAPA 16.03.25 - Rules Pertaining To The Idaho Medicaid Electronic Health Record (EHR) Incentive Program (New Chapter) (Docket No. 16-0325-1201).

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 07/31/2012. 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 08/28/2012.

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 334-4845, or send a written request to the address on the memorandum attached below.

Legislative Services Office
Idaho State Legislature

Jeff Youtz
Director

Serving Idaho's Citizen Legislature

MEMORANDUM

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

FROM: Legislative Research Analyst - Ryan Bush

DATE: July 12, 2012

SUBJECT: Department of Health and Welfare -

IDAPA 16.02.02 - Rules Pertaining To The Idaho Emergency Medical Services (EMS) Physician Commission (Docket No. 16-0202-1201)

IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits (Docket No. 16-0309-1203)

IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1204)

IDAPA 16.03.25 - Rules Pertaining To The Idaho Medicaid Electronic Health Record (EHR) Incentive Program (New Chapter) (Docket No. 16-0325-1201)

(1) 16.02.02 - Emergency Medical Services (EMS) Physician Commission (Docket No. 16-0202-1201)

The Emergency Medical Services (EMS) Physician Commission submits notice of proposed rulemaking at IDAPA 16.02.02 - Rules of the Idaho Emergency Medical Services (EMS) Physician Commission. The Commission states that the proposed rulemaking reflects the most recent edition of the Idaho Emergency Medical Services Physician Commission Standards Manual, edition 2013-1, which is incorporated by reference into these rules. Specifically, this proposed rulemaking would add to and revise how out-of-hospital medical supervision plans must be filed and submitted to the EMS Bureau and the EMS medical director. The proposed rule also requires the EMS medical director to notify the EMS Bureau of any change in the agency medical director.

The Commission states that negotiated rulemaking was not conducted because the proposed changes already represent extensive input from stakeholders. There is no negative fiscal impact resulting from this rulemaking.

The proposed rule appears to be within the authority granted to the Commission in Section 56-1023, Idaho Code.

(2) 16.03.09 - Medicaid Basic Plan Benefits (Docket No. 16-0309-1203)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.09 - Rules Pertaining To The Medicaid Basic Plan Benefits. The proposed rulemaking adds coverage of tobacco cessation products for pregnant women and children when prescribed by a physician and eliminates the regular dose fee and unit dose fee from dispensing fees. The Department states that this rulemaking is required under Title XIX, Section 1905(bb)(2) of the Social Security Act and that current Medicaid rules do not cover this specific circumstance. A similar rulemaking, Docket No. 16-0309-1201, was submitted to the

2012 Legislature but was rejected. The Legislature directed the Department to consider "Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline" published by the Public Health Service (PHS). The PHS guideline states that tobacco cessation products are not normally recommended for pregnant women but may be recommended on a case-by-case basis, as determined by a pregnant woman and her physician. This rulemaking allows for such coverage of tobacco cessation products.

The Department states that negotiated rulemaking was not conducted because the proposed changes are being done to bring the rules into compliance with the Social Security Act. The fiscal impact of this rulemaking is estimated to be less than $1000.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b), 56-253(8) and 56-264, Idaho Code.

(3) 16.03.10 - Medicaid Enhanced Plan Benefits (Docket No. 16-0310-1204)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.10 - Rules Pertaining To The Medicaid Enhanced Plan Benefits. The Department states that the proposed rulemaking will bring this chapter into alignment with changes made to Sections 56-255 and 56-264, Idaho Code, as amended by House Bill 609 (2012). House Bill 609 gave participants on the aged and disabled (A&D) waiver and the developmental disability (DD) waiver access to dental services that reflect evidence-based practices. House Bill 609 also allows for concurrent skill training by mental health providers and DD providers so long as the training relates to mental illness and a DD, is provided by professionals with mental health expertise, and the services are not duplicative. The proposed rulemaking is in conformity with and aligns the Department's rules regarding skill training with House Bill 609.

The Department states that negotiated rulemaking was not conducted because this rulemaking is being done to bring this chapter into compliance with House Bill 609. The fiscal impact resulting from this rulemaking is projected to be $1,500,000. The Department notes that these funds are included in the SFY 2013 budget for the Division of Medicaid.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b), 56-253(8) and 56-264, Idaho Code.

(4) 16.03.25 - Idaho Medicaid Electronic Health Record (EHR) Incentive Program (New Chapter) (Docket No. 16-0325-1201)

The Department of Health and Welfare submits notice of temporary and proposed rulemaking at IDAPA 16.03.25 - Rules Pertaining To The Idaho Medicaid Electronic Health Record (EHR) Incentive Program (New Chapter). The Department states that the proposed rulemaking is to administer the Medicaid Electronic Health Record (EHR) Incentive Program which disburses incentive payments to Medicaid providers who adopt, implement or upgrade to certified electronic health record systems. This program, in which Idaho has chosen to participate, was established by the American Reinvestment and Recovery Act of 2009 (ARRA), Section 4201, and 42 CFR Part 495. Specifically, this rulemaking accomplishes the following:

(1) Establishes the Medicaid Electronic Health Record (EHR) Incentive Program for Idaho;

(2) Defines terms;

(3) States legal authority and provides for administrative appeals;

(4) Provides for confidentiality of records and Public Records Act requests;

(5) Incorporates by reference 42 CFR Part 495, "Medicare and Medicaid Programs";

(6) Establishes criteria for eligibility in the program;

(7) Provides for the audit of providers receiving incentive payments; and

(8) Establishes state options under the program.

The Department states that negotiated rulemaking was not conducted because the federal Centers for Medicare and Medicaid Services is implementing the program and because it was not deemed feasible as this docket is a temporary rulemaking. There is no negative fiscal impact resulting from this rulemaking since the program is 100% federally funded.

The proposed rule appears to be within the authority granted to the Department in Sections 56-202(b), 56-203 and 56-1054, Idaho Code.

cc: Department of Health and Welfare - Medicaid Enhanced Plan Benefits
Tamara Prisock
Wayne Denny
Matt Wimmer
Mark Wasserman
Robert Kellerman

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

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

DOCKET NO. 16-0202-1201

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 56-1013A and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2012.

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

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

To best protect the public's health and safety, the EMS Physician Commission is revising its Standards Manual that is incorporated by reference in this chapter of rules. This revision to rule will ensure that the most recent edition of the manual has the force and effect of law.

Also, the text of the rule chapter needs some minor amendments to align it with changes in the Standards Manual approved by the 2012 Legislature.

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: N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was not conducted and deemed not feasible because the content of the proposed updates to the EMS Physician Commission Standards Manual and to this chapter of rules already represents extensive input from stakeholders gathered during 2011 and early 2012.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2013-1, is being incorporated by reference into these rules to give it the force and effect of law and because republishing the document in the rule would be unduly cumbersome and expensive due to its length and format.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Wayne Denny at (208) 334-4000.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 25, 2012.

DATED this 8th day of June, 2012.

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

THE FOLLOWING IS THE TEXT OF THE PROPOSED RULE FOR DOCKET NO. 16-0202-1201

004. INCORPORATION BY REFERENCE.
The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 201~~2~~3-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the Internet at www.emspc.dhw.idaho.gov or from the EMS Bureau located at 650 W. State Street, Suite B-17, Boise, Idaho, 83702, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036. ~~*(3-29-12)*~~( )

(BREAK IN CONTINUITY OF SECTIONS)

400. PHYSICIAN SUPERVISION IN THE OUT-OF-HOSPITAL SETTING.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director. (3-29-10)

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency. (3-29-10)

03. Delegated Medical Supervision of EMS Personnel. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director. (3-29-10)

04. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: (3-29-10)

a. A designated physician is not present in the anticipated receiving health care facility; and (4-2-08)

b. The Nurse Practitioner, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the Nurse Practitioner; or (4-2-08)

c. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide direct (on-line) supervision; and (4-2-08)

d. The PA, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the PA related to supervision of EMS personnel. (4-2-08)

e. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the EMS medical director. (4-2-08)

05. Indirect Medical Supervision by Non-Physicians. Non-physicians can assist the EMS medical director with indirect medical supervision of licensed EMS personnel. (3-29-10)

06. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency standards components. The requirements for the medical supervision plan are found in the Idaho EMS Physician Commission Standards Manual that is incorporated by reference under Section 004 of these rules. (3-29-10)

07. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must ~~*file*~~ submit the medical supervision plan~~*, including identification of the EMS medical director and any designated clinicians*~~ within thirty (30) days of request to the EMS Bureau in a form described in the standards manual. ~~*(4-2-08)*~~( )

a. The agency EMS medical director must identify the designated clinicians to the EMS Bureau annually in a form described in the standards manual. ( )

~~*a*~~**b.** The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or ~~*the medical supervision plan*~~ of a change in the agency medical director within thirty (30) days of the change(s). ~~*(4-2-08)*~~( )

~~*b*~~**c.** The EMS Bureau must provide the Commission with the medical supervision plans ~~*annually and upon*~~ within thirty (30) days of request. ~~*(4-2-08)*~~( )

~~*c*~~**d.** The EMS Bureau must provide the Commission with the identification of EMS Medical directors and designated clinicians annually and upon request. (4-2-08)

(BREAK IN CONTINUITY OF SECTIONS)

500. PHYSICIAN SUPERVISION IN HOSPITALS AND MEDICAL CLINICS.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician. (3-29-10)

02. Level of Licensure Identification. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic, when on duty, must at all times visibly display identification specifying their level of EMS licensure. (3-29-10)

03. Credentialing of Licensed EMS Personnel in a Hospital or Medical Clinic. The hospital or medical clinic must maintain a current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel and must submit the descriptions upon request of the Commission or the EMS Bureau. (3-29-10)

04. Notification of Employment or Utilization. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must report such employment or utilization to the EMS Bureau within thirty (30) days of engaging such activity. (3-29-10)

05. Designation of Supervising Physician. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic. (3-29-10)

06. Delegated Medical Supervision of EMS Personnel. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician. (3-29-10)

07. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The hospital supervising physician, or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: (3-29-10)

a. The Nurse Practitioner, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the Nurse Practitioner; or (4-2-08)

b. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide supervision; and (4-2-08)

c. The PA, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the PA related to supervision of EMS personnel. (4-2-08)

d. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician. (4-2-08)

08. On-Site Contemporaneous Supervision. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician, or designated clinicians. (3-29-10)

09. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan. The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan, and must submit the plan(s) ~~upon~~ within thirty (30) days of request ~~of~~ by the Commission or the EMS Bureau.
~~(3-29-10)~~( )

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1203

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective dates of the temporary rule are September 28, 2011, and March 29, 2012.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized by Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also Title XIX (Medicaid) of the Social Security Act, Section 1905(bb)(2), and Section 56-209(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

A revision to Title XIX, Section 1905(bb)(2) of the Social Security Act requires all State Medicaid Programs to cover tobacco cessation products and counseling for pregnant women and children. The Department submitted Docket No. 16-0309-1201 to cover tobacco cessation products for pregnant women and align this chapter with the federal mandate. The rulemaking was rejected by the 2012 Legislature under HCR 44 which directed the Department to promulgate a rule that considers the recommendations in "A Clinical Practice Guideline," published by the Public Health Service (PHS) in May 2008.

The guidelines on tobacco cessation treatment referenced by the legislature recommends strategies to assist clinicians in identifying and treating tobacco dependency. Idaho already covers the recommended strategies such as counseling, but under the current rules pharmacologic interventions are not available to Medicaid participants. The overview of the PHS clinical guidelines indicates that, "... although smoking cessation pharmaceuticals are not usually recommended for pregnant women, such use may be evaluated on a case-by-case basis, as determined by a woman and her physician."

Currently Medicaid rules do not cover this specific circumstance. These rule amendments will allow for coverage of tobacco cessation products for pregnant women and children when their physician determines that the products are necessary and safe for the health of the participant and the baby. Failure to align these rules with federal law may put the Department's federal matching funds at risk.

The Department also needs to make a change in the same Section of rules (662) to bring the rules into alignment with the Idaho Medicaid State Plan, and with Medicaid's reimbursement methodology defined in Section 56-209(g), Idaho Code. This rule change eliminates the reference to the unit dose fee for the dispensing of prescription medications.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is being done to comply with deadlines in amendments to governing law or federal programs, in particular, Title XIX, Section 1905(bb)(2) of the Social Security Act and Section 56-209(g), Idaho Code.

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

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

It is anticipated that the cost of this change will be less than $1000. The tobacco cessation products are rarely recommended for pregnant women and children, and all products would require prior authorization. During the past calendar year there have been no requests for these products. There is no fiscal impact associated with the removal of the reference to "unit dose fee."

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done in order to bring this chapter into compliance with Title XIX, Section 1905(bb)(2) of the Social Security Act and Section 56-209(g), Idaho Code. Negotiated rulemaking was not deemed feasible as this docket is a temporary rulemaking.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Matt Wimmer at (208) 364-1989.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 25, 2012.

DATED this 12th day of June, 2012.

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

THE FOLLOWING IS THE TEXT OF THE TEMPORARY AND PROPOSED RULE FOR DOCKET NO. 16-0310-1203

662. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. The Department will pay for those prescription drugs not excluded by Subsection 662.04 of these rules which are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of legend drugs, as defined under Section 54-1705(28), Idaho Code, and which are deemed medically necessary as defined in Section 011 of these rules. (3-30-07)

02. Dispensing Fee. Dispensing Fee is defined as the cost of filling a prescription including direct pharmacy overhead, ~~*and is one (1) of two (2) types*~~ and is for all services pertaining to the usual practice of pharmacy, including: ~~*(3-30-07)*~~(9-28-11)T

~~***a.** Regular Dose Fee. For services pertaining to the usual practice of pharmacy, including but not limited to:* (3-30-07)~~

~~***i***~~**a.** Interpretation, evaluation, compounding, and dispensing of prescription drug orders; (3-30-07)

~~ii~~**b.** Participation in drug selection; (3-30-07)

~~iii~~**c.** Drug administration; (3-30-07)

~~iv~~**d.** Drug regimen and research reviews; (3-30-07)

~~v~~**e.** Proper storage of drugs; (3-30-07)

~~vi~~**f.** Maintenance of proper records; (3-30-07)

~~vii~~**g.** Prescriber interaction; and (3-30-07)

~~viii~~**h.** Patient counseling. (3-30-07)

~~***b.*** *Unit Dose Fee. Unit-dose dispensing is defined as a system of providing individually sealed and appropriately labeled unit dose medication that ensures no more than a twenty-four (24) hour supply in any participant's drug tray at any given time. These drug trays, which contain a twenty four (24) hour supply of medication, must be delivered to the facility at a minimum of five (5) days per week.~~ ~~(3-30-07)~~

03. Limitations on Payment. Medicaid payment for prescription drugs will be limited as follows: (3-30-07)

a. Days' Supply. Medicaid will not cover any days' supply of prescription drugs that exceeds the quantity or dosage allowed by these rules. (3-30-07)

b. Brand Name Drugs. Medicaid will not pay for a brand name product that is part of the federal upper limit (FUL) or state maximum allowable cost (SMAC) listing when the physician has not specified the brand name drug to be medically necessary. (3-30-07)

c. Medication for Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. (3-30-07)

d. No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Section 663 of these rules. (3-30-07)

e. Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. (3-30-07)

04. Excluded Drug Products. The following categories and specific products are excluded from coverage by Medicaid: (3-30-07)

a. Non-Legend Medications. Federal legend medications that change to non-legend status, as well as their therapeutic equivalents regardless of prescription, status unless: (3-30-07)

i. They are included in Subsection 662.05.b. of these rules; or (3-30-07)

ii. The Director determines that non-legend drug products are covered based upon appropriate criteria including the following: safety, effectiveness, clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs, cost, and the recommendation of the Pharmacy And Therapeutics Committee. Therapeutically interchangeable is defined in Subsection 663.01.e. of these rules. (3-30-07)

b. Legend Drugs. Any legend drugs for which federal financial participation is not available. (3-30-07)

c. Diet Supplements. Diet supplements and weight loss products, except lipase inhibitors when prior authorized as outlined in Section 663 of these rules. (3-30-07)

d. Amphetamines and Related Products. Amphetamines and related products for cosmetic purposes or weight loss. Amphetamines and related products which are deemed to be medically necessary may be covered if prior authorized as outlined in Section 663 of these rules. (3-30-07)

e. Ovulation/Fertility Drugs. Ovulation stimulants, fertility drugs, and similar products. (3-30-07)

f. Impotency Aids. Impotency aids, either as medication or prosthesis. (3-30-07)

g. Tobacco Cessation Products. Nicotine chewing gum, sprays, inhalers, transdermal patches and related products, with the exception that both legend and non-legend tobacco cessation products will be covered for children and pregnant women when prescribed by their physician. ~~(3-30-07)~~(3-29-12)T

h. Medications Utilized for Cosmetic Purposes. Medications utilized for cosmetic purposes or hair growth. Prior authorization may be granted for these medications if the Department finds other medically necessary indications. (3-30-07)

i. Vitamins. Vitamins unless included in Subsection 662.05.a. of these rules. (3-30-07)

j. Dual Eligibles. Drug classes covered under Medicare, Part D, for Medicaid participants who are also eligible for Medicare. (3-30-07)

05. Additional Covered Drug Products. Additional drug products will be allowed as follows: (3-30-07)

a. Therapeutic Vitamins. Therapeutic vitamins may include: (3-30-07)

i. Injectable vitamin B12 (cyanocobalamin and analogues); (3-30-07)

ii. Vitamin K and analogues; (3-30-07)

iii. Pediatric legend vitamin-fluoride preparations; (3-30-07)

iv. Legend prenatal vitamins for pregnant or lactating women; (3-30-07)

v. Legend folic acid; (3-30-07)

vi. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; ~~and~~ ~~(3-30-07)~~(3-29-12)T

vii. Legend vitamin D and analogues~~.~~; and ~~(3-30-07)~~(3-29-12)T

viii. Legend smoking cessation products for pregnant women and children. (3-29-12)T

b. Prescriptions for Nonlegend Products. Prescriptions for nonlegend products may include: (3-30-07)

i. Insulin; (3-30-07)

ii. Disposable insulin syringes and needles; (3-30-07)

iii. Oral iron salts; ~~and~~ ~~(3-30-07)~~(3-29-12)T

iv. Permethrin~~.~~; and ~~(3-30-07)~~(3-29-12)T

v. Smoking cessation products for pregnant women and children. (3-29-12)T

06. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of

the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: (3-30-07)

a. Doses of Medication. Up to one hundred (100) doses of medication may be dispensed, not to exceed a one hundred (100) day supply for: (3-30-07)

i. Cardiac glycosides; (3-30-07)

ii. Thyroid replacement hormones; (3-30-07)

iii. Prenatal vitamins; (3-30-07)

iv. Nitroglycerin products - oral or sublingual; (3-30-07)

v. Fluoride and vitamin/fluoride combination products; and (3-30-07)

vi. Nonlegend oral iron salts. (3-30-07)

b. Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. (3-30-07)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.10 - MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-1204

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2012.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized by Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code; also House Bill 609 (2012).

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Rule changes are being made to bring this chapter into alignment with the changes made to Section 56-255(5)(c), Idaho Code, as amended under House Bill 609 (2012). Section 56-255(5)(c), Idaho Code (as amended), now states that "participants on the aged and disabled (A&D) waiver and the developmental disability (DD) waiver shall have access to dental services that reflect evidence-based practice." The Department is adding dental benefits to these two waivers to comply with the new state law, and revise the rules to reflect these changes.

House Bill 609 also amended Section 56-264(2)(6), Idaho Code, to allow concurrent skill training by mental health providers and developmental disability providers, so long as the mental health skills training relates to the mental illness and is provided by professionals who possess mental health expertise, and the training provided by the developmental disability provider relates to the developmental disability. These services may not be duplicative of each other. The Department is aligning the rules regarding skill training with the changes in the law.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(b), Idaho Code, the Governor has found that temporary adoption of the rule is being done to comply with deadlines in amendments to governing law or federal programs, in particular, House Bill 609 (2012).

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

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

Dental benefits will have an estimated fiscal impact of $600,000 to the state general fund. Skill training will have an estimated fiscal impact of $900,000 to the state general fund. The net cost to the state general fund is projected to be $1,500,000.

Note: HB 609 provided for these funds and they are included in the SFY 2013 budget for the Division of Medicaid.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is being done in order to bring this chapter into compliance with House Bill 609 (2012). Negotiated rulemaking was not deemed feasible as this docket is a temporary rulemaking.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

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

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 25, 2012.

DATED this 8th day of June, 2012.

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

THE FOLLOWING IS THE TEXT OF THE TEMPORARY AND PROPOSED RULE FOR DOCKET NO. 16-0310-1204

082. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children, adults, and pregnant women on Medicaid's Pregnant Woman (PW) Program who meet the eligibility criteria for Medicaid's Enhanced Plan are eligible for Idaho Smiles dental benefits described in Section 083 of these rules. Adults who are eligible for Medicaid's HCBS Aged and Disabled (A&D) Waiver or Developmental Disabilities (DD) Waiver are eligible for Idaho Smiles adult dental benefits and additional dental services described in Section 326.09 and Section 703.13 of these rules. Participants who are over age twenty-one (21), who are eligible for both Medicare A and Medicare B, and who have chosen to enroll in a Medicare/Medicaid Coordinated Plan (MMCP) under IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits," Section 100, receive dental benefits from the MMCP insurance carrier and not from Idaho Smiles. ~~(3-29-12)~~(7-1-12)T

083. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Some covered dental services may require authorization from the Idaho Smiles contractor. (3-29-12)

01. Dental Coverage for Children. Children are covered for dental services that include: (3-29-12)

a. Preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, prosthodontic, and orthodontic treatments, dentures, crowns and oral surgery; (3-29-12)

b. Other dental services that are determined medically necessary by the Department, as required by the Early and Periodic Screening and Diagnostic Testing (EPSDT) guidelines specified in Section 1905(r) of the Social Security Act, are also covered. (3-29-12)

02. Children's Orthodontics Limitations. Orthodontics are limited to children who meet the Enhanced Plan eligibility requirements, and the Idaho Medicaid Handicapping Malocclusion Index as evaluated by the state Medicaid dental consultant and the dental insurance contractor's dental consultant. The Malocclusion Index is found in Appendix A of these rules. (3-29-12)

03. Dental Coverage and Limitations for Adults. Adults who are not pregnant and who are not

covered under the A&D or DD Waivers are limited to the dental services coverage using the Current Dental Terminology (CDT) codes listed in the following table:

TABLE 083.03 - ADULT DENTAL SERVICES CODES

Dental Code	Description
D0140	Limited oral evaluation. Problem focused
D0220	Intraoral periapical film
D0230	Additional intraoral periapical films
D0330	Panoramic film
D7140	Extraction
D7210	Surgical removal of erupted tooth
D7220	Removal of impacted tooth, soft tissue
D7230	Removal of impacted tooth, partially bony
D7240	Removal of impacted tooth, completely bony
D7241	Removal of impacted tooth, with complications
D7250	Surgical removal of residual tooth roots
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7285	Biopsy of hard oral tissue
D7286	Biopsy of soft oral tissue
D7450	Excision of malignant tumor <1.25 cm
D7451	Excision of malignant tumor >1.25 cm
D7510	Incision and drainage of abscess
D7511	Incision and drainage of abscess, complicated
D9110	Minor palliative treatment of dental pain
D9220	Deep sedation/anesthesia first 30 minutes
D9221	Regional block anesthesia
D9230	Analgesia, anxiolysis, nitrous oxide
D9241	IV conscious sedation first 30 minutes
D9242	IV conscious sedation each additional 15 minutes
D9248	Non IV conscious sedation
D9420	Hospital call
D9610	Therapeutic parenteral drug single administration
D9630	Other drugs and/or medicaments by report

~~(3-29-12)~~(7-1-12)T

04. Dental Coverage for Pregnant Women. Pregnant women on Medicaid's Basic, Enhanced, or PW

plans are covered for preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, and oral surgery benefits. Specific information about pregnant women is available online at http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx. (3-29-12)

05. Benefit Limitations. The dental insurance contractor may establish limitations and restrictions for benefits according to the terms of its contract with the Department. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

112. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY. To qualify for enhanced outpatient mental health services, a participant must obtain a comprehensive diagnostic assessment as described in Section 114 of these rules. The comprehensive diagnostic assessment for enhanced outpatient mental health services must include documentation of the medical necessity for each service to be provided. For partial care services, the comprehensive diagnostic assessment must also contain documentation that shows the participant is currently at risk for an out-of-home placement, further clinical deterioration that would lead to an out-of-home placement, or further clinical deterioration that would interfere with the participant's ability to maintain his current level of functioning. ~~*Participants who receive skill training can only receive training from one (1) type of service, depending on their eligibility.*~~ ~~*(3-29-12)*~~(7-1-12)T

01. General Participant Eligibility Criteria. The medical record must have documented evidence of a history and physical examination that has been completed by a participant's primary care physician. This examination must be within the last twelve (12) months immediately preceding the initiation of mental health clinic services and annually thereafter. Providers must refer those participants who have not had a history and physical examination to their primary care provider for this service. Participants who are in crisis as described at Subsection 123.04 of this rule may receive mental health services prior to obtaining a history and physical examination. In order for a participant to be eligible for enhanced outpatient mental health services, the following criteria must be met and documented in the comprehensive diagnostic assessment: (5-8-09)

a. The service represents the least restrictive setting and other services have failed or are not appropriate for the clinical needs of the participant. (5-8-09)

b. The services can reasonably be expected to improve the participant's condition or prevent further regression so that the current level of care is no longer necessary or may be reduced. (4-2-08)

c. Participants identified in Subsections 112.01.c.i. through 112.01.c.iii. of this rule cannot participate in enhanced outpatient mental health services: (4-2-08)

i. Participants at immediate risk of self-harm or harm to others who cannot be stabilized; (4-2-08)

ii. Participants needing more restrictive care or inpatient care; and (4-2-08)

iii. Participants who have not fulfilled the requirements of Subsections 112.02 or 112.03 of these rules. (4-2-08)

02. Eligibility Criteria for Children. To be eligible for services, a participant under the age of eighteen (18) must have a serious emotional disturbance (SED). (5-8-09)

03. Eligibility Criteria for Adults. To be eligible for services, a participant must be eighteen (18) years or older and have a serious mental illness (SMI). (5-8-09)

04. Level of Care Criteria - Mental Health Clinics. To be eligible for mental health clinic services, a participant must meet the criteria as described in Subsections 112.04.a. and 112.04.b. of this rule. (4-2-08)

a. Children must meet Subsections 112.01 and 112.02 of this rule. (4-2-08)

b. Adults must meet Subsections 112.01 and 112.03 of this rule. (4-2-08)

05. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services for Children. (7-1-12)T

a. To be eligible for the PSR services of skill training and community reintegration, a child must meet the criteria of SED and Subsections 112.01 and 112.02 of this rule and must experience a substantial impairment in functioning. (7-1-12)T

b. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services. (7-1-12)T

c. A child's level and type of functional impairment must be documented in the medical record. The Child and Adolescent Functional Assessment Scale/Preschool and Early Childhood Functional Assessment Scale (CAFAS/PECFAS) instrument must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at regular intervals in order to determine the child's change in functioning that occurs as a result of mental health treatment. (7-1-12)T

d. Items endorsed on the CAFAS/PECFAS must be supported by specific descriptions of the child's observable behavior in the comprehensive diagnostic assessment. Substantial impairment requires that the child score in the moderate range in at least two (2) subscales on the CAFAS/PECFAS. One (1) of the two (2) subscales must be from the following list: self-harmful behavior, moods/emotions, or thinking. ~~(3-29-12)~~(7-1-12)T

~~**a.** *Self harmful behavior;* (4-2-08)~~

~~**b.** *Moods/Emotions; or* (4-2-08)~~

~~**c.** *Thinking.* (4-2-08)~~

06. Level of Care Criteria - Psychosocial Rehabilitation (PSR) Services and Partial Care Services for Adults. (7-1-12)T

a. To be eligible for partial care services or the PSR services of skill training and community reintegration, an adult must meet the criteria of SPMI and Subsection 112.01 of this rule. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas in Subsection 112.06.~~a~~c.i. through 112.06.~~b~~c.viii. of this rule on either a continuous or an intermittent, at least once per year, basis. (7-1-12)T

b. The participant's comprehensive diagnostic assessment must clearly identify the participant's need for skill training services that target skill deficits caused by his mental health condition. The participant's record must contain documentation that collaboration has occurred with the participant's other service providers in order to prevent duplication of skill training treatment services. (7-1-12)T

c. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the adult's level and type of functional impairment must be documented in the medical record in the following areas: ~~(3-29-12)~~(7-1-12)T

~~**a.**~~**i.** Vocational/educational; (4-2-08)

~~**b.**~~**ii.** Financial; (4-2-08)

~~**c.**~~**iii.** Social relationships/support; (4-2-08)

~~**d.**~~**iv.** Family; (4-2-08)

~~e~~v. Basic living skills; (4-2-08)

~~f~~vi. Housing; (4-2-08)

~~g~~vii. Community/legal; or (4-2-08)

~~h~~viii. Health/medical. (4-2-08)

07. Criteria Following Discharge For Psychiatric Hospitalization. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules are eligible for enhanced outpatient mental health clinic and PSR services. (3-19-07)

a. Children and adults discharged from psychiatric hospitalization and who meet the diagnostic criteria of the target population in these rules, described in Subsection 112.02 of this rule for children, and in Subsection 112.03 of this rule for adults, are considered immediately eligible for enhanced outpatient mental health services for a period of at least one hundred and twenty (120) days following discharge from the hospital. The individualized treatment plan must be completed and documented in the medical record within ten (10) days of discharge. (5-8-09)

i. Up to two (2) hours of plan development hours may be used for coordinating with hospital staff and others the participant chooses. These plan development hours are to be used for the development of an individualized treatment plan based on the participant's hospital records and past history. The provider agency does not have to perform any additional assessment in order to initiate treatment nor does the participant need to qualify as described in Section 114 of these rules. (5-8-09)

ii. Upon initiation of treatment at the agency, the treatment plan is valid for no more than one hundred twenty (120) days from the date of discharge from the hospital. A comprehensive diagnostic assessment or updated comprehensive diagnostic assessment addendum must be completed within ten (10) days of the initiation of treatment if one is not available from the hospital or if the one from the hospital does not contain the needed clinical information. (3-29-12)

b. In order for the participant to continue in the services listed on the post-hospitalization treatment plan beyond one hundred twenty (120) days, the plan must be updated and the provider must establish that the participant meets the criteria as described in Subsections 112.01 through 112.06 of this rule as applicable to the services being provided, and that enhanced outpatient mental health services are appropriate for the participant's age, circumstances, and medically necessary level of care. The PSR or mental health clinic provider does not need to submit form H0002 because the participant is already in the Enhanced Plan. (3-29-12)

(BREAK IN CONTINUITY OF SECTIONS)

118. ENHANCED OUTPATIENT MENTAL HEALTH SERVICES: DESCRIPTIONS.

01. Psychotherapy. Under the Medicaid Enhanced Plan, individual, family and group psychotherapy services are limited to forty-five (45) hours per calendar year. (3-19-07)

02. Partial Care Services. Under the Medicaid Enhanced Plan, partial care services are limited to twelve (12) hours per week per eligible participant. (5-8-09)

a. In order to be considered a partial care service, the service must: (3-19-07)

i. Be provided in a structured environment within the MHC setting; (3-19-07)

ii. Be identified as a service need through the participant's comprehensive diagnostic assessment and be indicated on the individualized treatment plan with documented, concrete, and measurable objectives and

outcomes; and (3-29-12)

iii. Provide interventions for relieving symptoms, stabilizing behavior, and acquiring specific skills. These interventions must include the specific medical services, therapies, and activities that are used to meet the treatment objectives. (5-8-09)

b. Staff Qualifications for Partial Care Services. Licensed, qualified professionals providing partial care services must have, at a minimum, one (1) or more of the qualifications listed in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Subsection 715.01. (3-19-07)

c. Excluded Services. Services that focus on vocation, recreation, or education are not reimbursable under Medicaid Partial Care. Services that are provided outside the clinic facility are not reimbursable. Participants who receive skill training in Partial Care cannot receive skill training in psychosocial rehabilitation~~, *developmental therapy, intensive behavioral intervention, or residential habilitation*~~ services. ~~*(3-29-12)*~~(7-1-12)T

(BREAK IN CONTINUITY OF SECTIONS)

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 four (4) hours per participant annually. The following assessments are included in this limitation: (3-29-12)

a. Comprehensive Diagnostic Assessment. This assessment, or an addendum to the existing assessment must be completed for each participant at least once annually; (3-29-12)

b. 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. Psychological and Neuropsychological Testing. Testing services are limited to two (2) computer-administered testing sessions and four (4) assessment hours per year. Additional testing must be prior authorized by the Department. Testing services are not included in the annual assessment limitation described at Subsection 124.01. The duration of psychological and neuropsychological testing is determined by the participant's benefits and the presenting reason for such an assessment. (3-29-12)

03. Individualized Treatment Plan. Two (2) hours are available for the development of the participant's initial treatment plan. Following the development of the initial treatment plan, all subsequent treatment must be based on timely updates to the initial plan. Treatment plan updates are considered part of the content of care and should occur as an integral part of the participant's treatment experience. (3-29-12)

04. 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)

05. 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)

06. 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 for eligible participants up to twenty-one (21) years of age. For participants aged twenty-one (21) years of age or older, services are limited to four (4) hours weekly in any combination of individual or group skill training and community reintegration. Participants who receive skill training in psychosocial rehabilitation cannot receive skill training in partial care~~, *developmental*~~

~~*therapy, intensive behavioral intervention, or residential habilitation services*~~. Participants with both a developmental disability diagnosis and a qualifying mental health diagnosis, who want to receive skill training services from a PSR agency provider, in addition to a developmental disability service provider must obtain authorization from the Department prior to service implementation. ~~*(3-29-12)*~~(7-1-12)T

07. Pharmacological Management. Pharmacological management services beyond twenty-four (24) encounters 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)

(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. 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, school or 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. Dental Services. Dental services include exams, radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in these rules are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Waiver dental services are limited to participants who are past the month of their twenty-first birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan. (7-1-12)T

~~09~~10. 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)

1~~0~~1. 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)

1~~1~~2. 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~~2~~3. **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~~3~~4. **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~~4~~5. **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~~5~~6. **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)

167. 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)

178. 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) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment 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)

1~~8~~9. 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)

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)

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

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

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

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

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

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

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

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

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

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

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

03. Provider Qualifications. All providers of homemaker, 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 cannot be a relative of any participant to whom the provider is supplying services. (3-19-07)

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

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

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

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

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

04. 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)

05. 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. 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. 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)

08. 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)

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)

10. 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)

11. 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 History and Background Checks." (4-2-08)

12. 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)

13. Assisted Transportation Services. See Subsection 329.03 of this rule for provider qualifications. (3-19-07)

14. Attendant Care. See Subsection 329.03 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)

15. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (4-2-08)

16. 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)

17. Residential Habilitation Supported Living Provider Qualifications. Residential habilitation supported living services must be provided by an agency that is capable of supervising the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (3-29-12)

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 329.18.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 qualified by a program coordinator who is approved by the Department. (3-29-12)

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 with the residential habilitation agency and include at a minimum: (3-29-12)

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

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

iii. Feeding; (3-30-07)

iv. Communication; (3-30-07)

v. Mobility; (3-30-07)

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

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

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

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

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)

19. Residential Habilitation Program Coordination for Certified Family Home Providers. 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" and must receive residential habilitation program coordination from a qualified program coordinator approved by the Department. Non-compliance with the certification process is cause for termination of the provider agreement or contract. (3-29-12)

20. 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)

21. 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)

22. 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)

23. Dental Services. Providers are credentialed by the contractor to ensure they meet the licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (7-1-12)T

(BREAK IN CONTINUITY OF SECTIONS)

651. DDA SERVICES: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental disabilities agency services must be recommended by a physician or other practitioner of the healing arts. The following therapy services are reimbursable when provided in accordance with these rules. (7-1-11)

01. Required DDA Services. Each DDA is required to provide developmental therapy; in addition, each DDA must provide or make available the following services: psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy. Developmental therapy must be provided by qualified employees of the agency. Psychotherapy, occupational therapy, physical therapy, and speech and hearing therapy must either be provided by qualified employees of the agency or through a formal written agreement. (7-1-11)

a. Sufficient Quantity and Quality. All required services provided must be sufficient in quantity and quality to meet the needs of each person receiving services, and must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. (7-1-11)

b. When a Required Service Is Not Available. When a required service, other than developmental therapy, is not provided by the agency due to a documented shortage of available providers in a specific geographic area, the DDA must document its effort to secure the service or facilitate the referral for the needed service, including notifying the service coordinator, when the participant has one. (7-1-11)

02. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. 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. Developmental therapy services must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on a comprehensive developmental assessment completed prior to the delivery of developmental therapy. ~~*Developmental therapy will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.*~~ ~~*(3-29-12)*~~(7-1-12)T

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or mental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-11)

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in his life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. (7-1-11)

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. (7-1-11)

d. Settings for Developmental Therapy. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. (7-1-11)

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct

services for every twelve (12) participants. Additional staff must be added, as necessary, to meet the needs of each individual served. (7-1-11)

03. Psychotherapy Services. The following psychotherapy services must be available through each agency and based on assessment(s) conducted by the professional qualified to deliver the service: (7-1-11)

a. Individual psychotherapy; (7-1-11)

b. Group psychotherapy in which there is a minimum ratio of one (1) qualified staff person for every twelve (12) individuals in group therapy; and (7-1-11)

c. Family-centered psychotherapy that includes the participant and at least one (1) other family member at any given time. (7-1-11)

d. Psychotherapy services are limited to a maximum of forty-five (45) hours in a calendar year, including individual, group, and family-centered. (3-29-12)

e. Psychotherapy services must be provided by one (1) of the following qualified professionals: (7-1-11)

i. Licensed Psychiatrist; (7-1-11)

ii. Licensed Physician; (7-1-11)

iii Licensed Psychologist; (7-1-11)

iv. Licensed Clinical Social Worker; (7-1-11)

v. Licensed Clinical Professional Counselor; (7-1-11)

vi. Licensed Marriage and Family Therapist; (7-1-11)

vii. Certified Psychiatric Nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree; (7-1-11)

viii. Licensed Professional Counselor whose provision of psychotherapy is supervised by persons qualified above under Subsections 651.03.e.i. through 651.03.e.vii. of this rule; (7-1-11)

ix. Registered Marriage and Family Therapist Intern whose provision of psychotherapy is supervised as described in Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

x. 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 (7-1-11)

xi. A Psychologist Extender, registered with the Bureau of Occupational Licenses, whose provision of psychotherapy is supervised as described in IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-11)

04. 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. Occupational therapy services must be available and provided by a licensed occupational therapist and be based on the results of an occupational therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

05. 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.

Physical therapy services must be available and provided by a licensed physical therapist and be based on the results of a physical therapy assessment completed in accordance with Section 655 of these rules. (7-1-11)

06. 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. Speech-language pathology services must be available and provided by a qualified speech-language pathologist, as defined in these rules, and be based on the results of a speech and language assessment completed in accordance with Section 655 of these rules. (7-1-11)

07. Optional Services. DDAs may opt to provide any of the following services: pharmacological management, psychiatric diagnostic interviews, community crisis supports, and Intensive Behavioral Intervention (IBI). All services must be provided by qualified individuals in accordance with the requirements in Section 657 of these rules. (3-29-12)

08. 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. (7-1-11)

09. Psychiatric Diagnostic Interview. A psychiatric diagnostic interview must include a history, a current mental status examination, and offer recommendations for treatment interventions needed, if any. If the interview exam results in a recommendation for additional intervention and the recommendation is accepted by the participant and his parent or legal guardian, if applicable, the recommendation must be incorporated into the participant's plan of service with the type, amount, frequency, and duration of service specified. (7-1-11)

a. Physician Requirement. In order for a DDA to conduct a psychiatric diagnostic interview, the agency must have a physician on contract for the purpose of overseeing the services on the plan. (7-1-11)

b. On Plan of Service. A psychiatric diagnostic interview must be incorporated into the participant's plan of service. (7-1-11)

c. Staff Qualifications. A psychiatric diagnostic interview must be conducted by one (1) of the following professionals, in direct face-to-face contact with the participant: (7-1-11)

i. Psychiatrist; (7-1-11)

ii. Physician or other practitioner of the healing arts; (7-1-11)

iii. Psychologist; (7-1-11)

iv. Clinical social worker; or (7-1-11)

v. Clinical professional counselor. (7-1-11)

10. Community Crisis Supports. Community crisis supports are interventions for adult 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. DDAs that choose to provide these services must do so in accordance with Sections 507 through 515 of these rules. (7-1-11)

11. Intensive Behavioral Intervention. DDA's that choose to offer Intensive Behavioral Intervention (IBI) must provide IBI services in accordance with Sections 656 of these rules. (7-1-11)

a. IBI is limited to a lifetime limit of thirty-six (36) months. (7-1-11)

b. The DDA must receive prior authorization from the Department prior to delivering IBI services. (7-1-11)

c. IBI must only be delivered on an individualized, one-to-one (1 to 1) basis. (7-1-11)

~~***d.*** *Intensive behavioral intervention services will not be reimbursed if the participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.* *(3-29-12)*~~

~~e~~d. After July 1, 2006, agencies must have provided developmental therapy for at least one (1) year and not be operating under a provisional certification prior to providing IBI services. (3-29-12)

~~f~~e. Agencies that were providing IBI services prior to July 1, 2006, are exempt from the requirement under Subsection 651.12.d. of this rule. (3-29-12)

~~g~~f. IBI consultation, as described in Section 656 of these rules, is included in the thirty-six (36) month IBI limitation. The DDA must receive prior authorization from the Department prior to providing IBI Consultation. (3-29-12)

12. Excluded Services. The following services are excluded for Medicaid payments: (7-1-11)

a. Vocational services; (7-1-11)

b. Educational services; and (7-1-11)

c. Recreational services. (7-1-11)

13. Limitations on DDA Services. DDA therapy services may not exceed the limitations as specified below. (3-29-12)

a. The combination of therapy services listed in Subsections 651.02 through 651.06, and 651.11 of this rule must not exceed twenty-two (22) hours per week. (3-29-12)

b. Therapy services listed in Subsections 651.02 through 651.06, and 651.11 of this rule, provided in combination with Community Supported Employment services under Subsection 703.04 of these rules, must not exceed forty (40) hours per week. (3-29-12)

c. When an 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. (7-1-11)

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. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

657. DDA SERVICES: DDA PROVIDER QUALIFICATIONS AND DUTIES.

01. Audiologist, Licensed. A person licensed to conduct hearing assessment and therapy, in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who either possesses a certificate of clinical competence in audiology from the American Speech, Language and Hearing Association (ASHA) or will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification. (7-1-11)

02. Counselor, Licensed Clinical Professional. A person licensed to practice as a clinical professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing

Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

03. Counselor, Licensed Professional. A person licensed to practice as a professional counselor in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

04. Marriage and Family Therapist. (7-1-11)

a. Licensed Marriage and Family Therapist. A person licensed to practice as a marriage and family therapist in accordance with Title 54, Chapter 34, Idaho Code and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

b. Registered Marriage and Family Therapist Intern. A person registered to practice as a marriage and family therapist intern under the direct supervision of a Licensed Marriage and Family Therapist, in accordance with Title 54, Chapter 34, Idaho Code, and IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists." (7-1-11)

05. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: (7-1-11)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (7-1-11)

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: (7-1-11)

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (7-1-11)

ii. Passed a competency examination approved by the Department. (7-1-11)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-11)

06. Developmental Specialist for Children Three Through Seventeen. A Developmental Specialist providing developmental assessment and therapy services to children ages three (3) through seventeen (17) must meet the requirements for a Developmental Specialist for adults, and must also meet the following requirements: (7-1-11)

a. Successfully complete a competency course approved by the Department that relates to developmental assessment and therapy for children; and (7-1-11)

b. Pass a competency examination approved by the Department. (7-1-11)

07. Developmental Therapy Paraprofessionals Delivering Services to Participants Age Three and Older. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children age (3) and older if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. (7-1-11)

08. Developmental Specialist for Children Birth to Three. (7-1-11)

a. To provide developmental assessments and therapy to children birth to three (3) years of age, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young

children who have developmental disabilities and one (1) of the following: (7-1-11)

i. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

ii. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; (7-1-11)

iii. A bachelor's or masters degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

(1) Promotion of development and learning for children from birth to three (3) years; (7-1-11)

(2) Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

(3) Building family and community relationships to support early interventions; (7-1-11)

(4) Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

b. Electives closely related to the content under Subsection 657.08.a.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

c. A developmental specialist who possesses a bachelor's or master's degree listed above under Subsection 657.08.a.ii. of this rule, must have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with his approved, conditional hiring agreement. (7-1-11)

d. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. An individual who has an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as he demonstrates satisfactory progress on the plan and complete the requirements on the plan within three (3) years of his date of hire. (7-1-11)

09. Developmental Therapy Paraprofessionals Delivering Services to Children Birth to Three. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy to children birth to three (3) years of age if they are under the supervision of a Developmental Specialist fully qualified to provide services to participants in this age group. Developmental therapy paraprofessionals serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)

a. Be at least eighteen (18) years of age; (7-1-11)

b. Be a high school graduate or have a GED; and (7-1-11)

c. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the equivalent through completion of twelve (12) semester credits from an accredited college or university in child development, special education or closely-related coursework; or (7-1-11)

d. Have three (3) years of documented experience providing care to infants, toddlers, or children less than five (5) years of age with developmental delays or disabilities under the supervision of a child development professional, certified educator, licensed therapist, or Developmental Specialist. (7-1-11)

10. Intensive Behavioral Intervention (IBI) Professional Delivering Services to Participants Three to Twenty-One. A person qualified to provide or direct the provision of Intensive Behavioral Intervention (IBI) must meet the following requirements: (7-1-11)

a. Degree. A qualified IBI professional must hold at least a bachelor's degree in a health, human services, educational, behavioral science, or counseling field from a nationally accredited university or college. (7-1-11)

b. Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. The year's experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. (7-1-11)

c. Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410. (7-1-11)

11. IBI Paraprofessionals Delivering Services to Participants Three to Twenty-One. A certified IBI paraprofessional may be used to provide IBI under the supervision of a certified IBI professional and must comply with Section 658 of these rules. An IBI paraprofessional must also: (7-1-11)

a. Be at least eighteen (18) years of age; (7-1-11)

b. Experience. An individual applying for IBI paraprofessional or professional certification must be able to provide documentation of one (1) year of supervised experience working with children with developmental disabilities. The year of experience must be gained through paid employment or university practicum experience or internship and be documented to include one thousand (1,000) hours of direct contact or care of children with developmental disabilities in a behavioral context. (7-1-11)

c. Training and Certification. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410. (7-1-11)

12. IBI Professionals Delivering Services to Children Birth to Three. A person qualified to provide or direct the provision of IBI to children under three (3) years of age must meet the staff qualifications described under Subsections 657.08.a.ii. through 657.08.d. of these rules, 657.10.b. and 657.10.c. of these rules and the certification and training requirements above under Subsections 658.01.e. and 658.01.f. of these rules. (7-1-11)

13. IBI Paraprofessionals Delivering Services to Children Birth to Three. A paraprofessional serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)

a. Be at least eighteen (18) years of age; (7-1-11)

b. Be a high school graduate or have a GED; and (7-1-11)

c. Have transcripted courses for a minimum of a Child Development Associate degree (CDA) or the

equivalent through completion of twelve (12) credits in child development, special education, or closely-related coursework; or (7-1-11)

d. Have three (3) years of documented experience providing care to infants, toddlers or children under five (5) years of age under the supervision of a child development professional, certified educator, or licensed therapist or Developmental Specialist. (7-1-11)

e. Qualified IBI professionals and paraprofessionals must comply with the requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410, and Subsections 658.01.e. and 658.01.f. of these rules. (7-1-11)

14. Nurse Practitioner. A licensed professional nurse (RN) who has met all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." (7-1-11)

15. Occupational Therapist. A person qualified to conduct occupational therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.09, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants." (7-1-11)

16. Physical Therapist. A person qualified to conduct physical therapy assessments and therapy in accordance with the requirements in IDAPA 22.01.05, "Licensure of Physical Therapists Idaho State Board of Medicine and Physical Therapist Assistants." (7-1-11)

17. Physician. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code. (7-1-11)

18. Physician Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: (7-1-11)

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or (7-1-11)

b. Has satisfactorily completed a program for preparing physician's assistants that: (7-1-11)

i. Was at least one (1) academic year in length; and (7-1-11)

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and (7-1-11)

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (7-1-11)

19. Psychiatric Nurse, Certified. A licensed professional nurse (RN), licensed in accordance with Title 54, Chapter 14, Idaho Code, or certified by a recognized national certification organization, and have a minimum of a master's degree. (7-1-11)

20. Psychiatrist. A person licensed to practice medicine in Idaho in accordance with the provisions of the Medical Practice Act, Title 54, Chapter 18, Idaho Code, and who meets the requirements for certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. (7-1-11)

21. Psychologist. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." (7-1-11)

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

(7-1-11)

23. Social Worker, Licensed. A person licensed in accordance with the Social Work Licensing Act, Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-11)

24. Masters Social Worker, Licensed. A person who is licensed as a masters social worker (LMSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-11)

25. Clinical Social Worker, Licensed. A person who is licensed as a clinical social worker (LCSW) in accordance with Title 54, Chapter 32, Idaho Code and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (7-1-11)

26. Speech-Language Pathologist, Licensed. A person licensed to conduct speech-language assessment and therapy in accordance with the Speech and Hearing Services Practice Act, Title 54, Chapter 29, Idaho Code, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. The agency's personnel records must reflect the expected date of certification. (7-1-11)

27. Requirements for Collaboration with Other Providers. (7-1-12)T

a. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the Psychosocial Rehabilitation (PSR) plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. (7-1-12)T

b. A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition. (7-1-12)T

(BREAK IN CONTINUITY OF SECTIONS)

685. CHILDREN'S WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Family Training. Providers of family training must meet the requirements for habilitative intervention providers defined in Subsections 685.03 and 685.04 of this rule. (7-1-11)

02. Interdisciplinary Training. Providers of interdisciplinary training must meet the following requirements: (7-1-11)

a. Occupational Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

b. Physical Therapist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

c. Speech-Language Pathologist, as defined in Section 734 under IDAPA 16.03.09, "Medicaid Basic Plan Benefits"; (7-1-11)

d. Practitioner of the healing arts; (7-1-11)

e. Habilitative intervention provider as defined in Subsections 685.03 and 685.04 of this rule; or (7-1-11)

f. Therapeutic consultation provider as defined in Subsection 685.05 of this rule. (7-1-11)

03. Habilitative Intervention. Habilitative intervention must be provided by a DDA certified to provide both support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," and is capable of supervising the direct services provided. Providers of habilitative intervention must meet the following minimum qualifications: (7-1-11)

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

b. Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities. Experience must be gained through paid employment or university practicum experience or internship; (7-1-11)

c. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative intervention; or (7-1-11)

d. Individuals working as Developmental Specialists for children age birth through three (3) or three (3) through 17, and individuals certified as Intensive Behavioral Intervention professionals prior to July 1, 2011, are qualified to provide habilitative intervention until June 30, 2013. The individual must meet the requirements of the Department-approved competency coursework by June 30, 2013 to maintain his certification. (7-1-11)

04. Habilitative Intervention for Children Birth to Three. In addition to the habilitative intervention qualifications listed in Subsections 685.04.a. through d. of this rule, habilitative intervention staff serving infants and toddlers from birth to three (3) years of age must have a minimum of two hundred forty (240) hours of professionally-supervised experience with young children who have developmental disabilities and one (1) of the following: (7-1-11)

a. An Elementary Education Certificate or Special Education Certificate with an Endorsement in Early Childhood Special Education; or (7-1-11)

b. A Blended Early Childhood/Early Childhood Special Education (EC/ECSE) Certificate; or (7-1-11)

c. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, or nursing plus a minimum of twenty-four (24) semester credits in Early Childhood/Early Childhood Special Education (EC/ECSE) from an accredited college or university. Courses taken must appear on college or university transcripts and must cover the following standards in their content: (7-1-11)

i. Promotion of development and learning for children from birth to three (3) years; (7-1-11)

ii. Assessment and observation methods for developmentally appropriate assessment of young children; (7-1-11)

iii. Building family and community relationships to support early interventions; (7-1-11)

iv. Development of appropriate curriculum for young children, including IFSP and IEP development; (7-1-11)

v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children who are medically fragile and their families; and (7-1-11)

vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-11)

d. Electives closely related to the content under Subsection 685.04.c.iii. of this rule may be approved by the Department with a recommendation from an institution of higher education. (7-1-11)

e. Developmental specialists who possess a bachelor's or master's degree listed above under Subsection 685.04.c.ii. of this rule, have completed a minimum of twenty (20) semester credits in EC/ECSE, and with Department approval are serving children under three (3) years of age as of July 1, 2005, will be allowed to continue providing services in accordance with their approved, conditional hiring agreement. (7-1-11)

f. When the Department in its role as lead agency for implementation of Part C of the Individuals with Disabilities Education Act (IDEA) has determined that there is a shortage of such qualified personnel to meet service needs in a specific geographic area: (7-1-11)

i. The Department may approve the most qualified individuals who are demonstrating satisfactory progress toward completion of applicable course work in accordance with the individual's approved plan to meet the required standard within three (3) years of being hired. (7-1-11)

ii. Satisfactory progress will be determined on an annual review by the Department. (7-1-11)

iii. Individuals who have an approved plan for completion of twenty (20) semester credits in EC/ECSE prior to July 1, 2005, will be allowed to continue providing services so long as they demonstrate satisfactory progress on the plan and complete the requirements on the plan within three (3) years of their date of hire. (7-1-11)

05. Therapeutic Consultation. Therapeutic consultation may be provided by a DDA certified to provide both supports and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of therapeutic consultation must meet the following minimum qualifications: (7-1-11)

a. Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and (7-1-11)

b. Two (2) years relevant experience in designing and implementing comprehensive behavioral therapies for children with DD and challenging behavior. (7-1-11)

c. Therapeutic consultation providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

d. Therapeutic consultation providers employed by a DDA must be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21 "Developmental Disabilities Services (DDA)." Independent therapeutic consultation providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-11)

06. Crisis Intervention. Crisis intervention may be provided by a DDA certified to provide support and intervention services under IDAPA 16.03.21, "Developmental Disabilities Services (DDA)," or by an independent Medicaid provider under agreement with the Department. Providers of crisis intervention must meet the following minimum qualifications: (7-1-11)

a. Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.04 of this rule. (7-1-11)

b. Emergency intervention technician providers must meet the minimum habilitative support provider

qualifications described under Subsection 665.02 of these rules. (7-1-11)

c. Crisis intervention providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." (7-1-11)

07. Continuing Training Requirements for Professionals. Each professional providing waiver services must complete at least twelve (12) hours of yearly training, six (6) hours of which must cover behavior methodology or interventions shown to be effective. If the individual has not completed the required training during any yearly training period, he may not provide waiver services beginning with the anniversary date of the following period, and thereafter, until the required number of training hours have accumulated. As training hours accumulate, they will be accounted first to any training-deficient prior yearly period before being applied to the current annual training period. Training hours may not be earned in a current annual training period to be applied to a future training period. (7-1-11)

08. Requirements for Clinical Supervision. All DDA services must be provided under the supervision of a clinical supervisor. The clinical supervisor must meet the qualifications to provide habilitative intervention as defined in this rule. Clinical supervisor(s) are professionals employed by a DDA on a continuous and regularly scheduled basis. (7-1-11)

a. The clinical supervisor is responsible for the oversight and supervision of service and support elements of the agency, including face-to-face supervision of agency staff providing direct services. (7-1-11)

b. The clinical supervisor must observe and review the direct services performed by all paraprofessional and professional staff on a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services and support. (7-1-11)

c. Each DDA must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-11)

09. Requirements for Collaboration with Other Providers. (7-1-12)T

a. Providers of waiver services must coordinate with the family-centered planning team as specified on the plan of service. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. (7-1-11)

b. A participant who is seeking skill training from a PSR agency provider as well as a Developmental Disabilities service provider may receive services from both if the service objectives are not duplicative, and the comprehensive diagnostic assessment described in Section 114 of these rules clearly identifies the participant's need for skill training services that target skill deficits caused by the mental health condition. (7-1-12)T

10. Requirements for Quality Assurance. Providers of children's waiver services must demonstrate high quality of services, including treatment fidelity, through an internal quality assurance review process. (7-1-11)

11. DDA Services. In order for a DDA to provide waiver services, the DDA must be certified to provide both support and intervention services. Each DDA is required to provide habilitative supports. When a DDA opts to provide habilitative intervention services, the DDA must also provide habilitative supports and family training. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)

703. ADULT DD 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)

~~***d.*** *Residential Habilitation services will not be reimbursed if a participant is receiving psychosocial rehabilitation or partial care services as this is a duplication of services.* *(3-29-12)*~~

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 cannot 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 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

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 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

13. Dental Services. Dental services include exams radiographs, diagnostic and preventative services, basic restorations, periodontics, oral surgery, maxillofacial surgery, and adjunctive dental services. These services and the medically necessary dental benefits described in these rules are provided through the Idaho Smiles program. The State's Medicaid dental contract for the Idaho Smiles program includes the complete list of all dental services available to waiver participants. Waiver dental services are limited to participants who are past the month of their twenty-first birthdays. Waiver participants who are under age twenty-one (21) will continue to receive children's dental benefits under the State Plan. (7-1-12)T

134. 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)

145. 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 Intellectual Disabilities (ICF/ID); 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)

(BREAK IN CONTINUITY OF SECTIONS)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-19-07)

01. Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Rules Governing Residential Habilitation Agencies," and must be capable of supervising the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (3-29-12)

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 agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: (3-29-12)

i. Purpose and philosophy of services; (3-19-07)

ii. Service rules; (3-19-07)

iii. Policies and procedures; (3-19-07)

iv. Proper conduct in relating to waiver participants; (3-19-07)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-19-07)

vi. Participant rights; (3-19-07)

vii. Methods of supervising participants; (3-19-07)

viii. Working with individuals with developmental disabilities; and (3-19-07)

ix. Training specific to the needs of the participant. (3-19-07)

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

i. Instructional techniques: Methodologies for training in a systematic and effective manner; (3-19-07)

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; (3-19-07)

iii. Feeding; (3-19-07)

iv. Communication; (3-19-07)

v. Mobility; (3-19-07)

vi. Activities of daily living; (3-19-07)

vii. Body mechanics and lifting techniques; (3-19-07)

viii. Housekeeping techniques; and (3-19-07)

ix. Maintenance of a clean, safe, and healthy environment. (3-19-07)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-19-07)

02. Residential Habilitation -- Certified Family Home (CFH). (3-29-12)

a. An individual who provides direct residential habilitation services in his own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Rules Governing Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services he provides. (3-29-12)

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: (3-29-12)

i. Be at least eighteen (18) years of age; (3-29-12)

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (3-29-12)

iii. Have current CPR and First Aid certifications; (3-29-12)

iv. Be free from communicable diseases; (3-29-12)

v. Each CFH provider of residential habilitation services 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.

(3-29-12)

vi. CFH providers of residential habilitation services who provide direct care and services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" and (3-29-12)

vii. Have appropriate certification or licensure if required to perform tasks which require certification or licensure. (3-29-12)

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. (3-29-12)

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: (3-29-12)

i. Purpose and philosophy of services; (3-29-12)

ii. Service rules; (3-29-12)

iii. Policies and procedures; (3-29-12)

iv. Proper conduct in relating to waiver participants; (3-29-12)

v. Handling of confidential and emergency situation that involve the waiver participant; (3-29-12)

vi. Participant rights; (3-29-12)

vii. Methods of supervising participants; (3-29-12)

viii. Working with individuals with developmental disabilities; and (3-29-12)

ix. Training specific to the needs of the participant. (3-29-12)

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: (3-29-12)

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; (3-29-12)

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; (3-29-12)

iii. Feeding; (3-29-12)

iv. Communication; (3-29-12)

v. Mobility; (3-29-12)

vi. Activities of daily living; (3-29-12)

vii. Body mechanics and lifting techniques; (3-29-12)

viii. Housekeeping techniques; and (3-29-12)

ix. Maintenance of a clean, safe, and healthy environment. (3-29-12)

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. (3-29-12)

03. Chore Services. Providers of chore services must meet the following minimum qualifications: (3-19-07)

a. Be skilled in the type of service to be provided; and (3-19-07)

b. Demonstrate the ability to provide services according to a plan of service. (3-19-07)

c. Chore service providers who provide direct care and services 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. 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)

05. 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)

06. 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)

07. 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)

08. 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)

09. 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)

10. Home Delivered Meals. Services of Home Delivered Meals under this Subsection may only be provided by an agency capable of supervising the direct service and must: (7-1-11)

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)

11. 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)

12. 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 Intellectual Disabilities Professional (QIDP). (3-19-07)

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, “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)

13. Adult Day Care. Providers of adult day care services must notify the Department or its contractor

for residential habilitation program coordination, on behalf of the participant, if the adult day care is provided in a certified family home other than the participant's primary residence. The adult day care provider must 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: (3-29-12)

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)

14. **Dental Services**. Providers are credentialed by the contractor to ensure they meet the licensing requirements of the Idaho Board of Dentistry. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. (7-1-12)T

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

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.25 - IDAHO MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

DOCKET NO. 16-0325-1201 (NEW CHAPTER)

NOTICE OF RULEMAKING - TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2012.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized by Sections 56-202, 56-203, and 56-1054, Idaho Code; also the American Reinvestment and Recovery Act of 2009 (ARRA), Section 4201, and 42 CFR Part 495.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 18, 2012.

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

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Department is adopting a new chapter of rules to administer the Medicaid Electronic Health Record (EHR) Incentive Program in which it has opted to participate. Section 4201 of the ARRA established this voluntary program to disburse incentive payments to Medicaid providers who adopt, implement, or upgrade to become meaningful users of certified electronic health record systems.

This new chapter of rules will encompass the Medicaid EHR Incentive Program state criteria for eligible professionals and eligible hospitals.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is being done to confer a benefit in accordance with the ARRA, Section 4201 and 42 CFR Part 495.

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

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

The state general fund impact is neutral for this rulemaking. The Department will use existing resources to make this program operational. Through the authority of the ARRA the Department will pay 100% federally funded incentive payments to eligible providers in Idaho to purchase and maintain certified Electronic Health Record systems.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the federal Centers for Medicare and Medicaid Services (CMS) is implementing the program and the money is enhancing the efficiency of providers and improving patients' experience. Negotiated rulemaking was not deemed feasible as this docket is a temporary rulemaking.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, 42 CFR Part 495, revised October 1, 2011 (http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5.pdf), is being incorporated by reference into these rules to give it the force and effect of law under these rules. These federal regulations are not being reprinted in this chapter of rules due to its length and format and because of the cost for republication.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary and proposed rule, contact Robert Kellerman at (208) 364-1994.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 25, 2012.

DATED this 14th day of June, 2012.

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

THE FOLLOWING IS THE TEXT OF THE TEMPORARY AND PROPOSED RULE FOR DOCKET NO. 16-0325-1201

IDAPA 16
TITLE 03
CHAPTER 25

16.03.25 - IDAHO MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

000. LEGAL AUTHORITY.

01. Rulemaking Authority. Under Sections 56-202, 56-203, and 56-1054, Idaho Code, the Idaho Department of Health and Welfare has the authority to adopt rules regarding the Idaho Medicaid Electronic Health Record (EHR) Incentive Program. (7-1-12)T

02. General Administrative Authority. The American Reinvestment and Recovery Act of 2009 (ARRA), Section 4201, and 42 CFR Part 495, provide the basic authority for administration of this federal program. (7-1-12)T

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.25, "Idaho Medicaid Electronic Health Record (EHR) Incentive Program." (7-1-12)T

02. Scope. These rules: (7-1-12)T

a. Establish the Medicaid Electronic Health Record (EHR) Incentive Program for Idaho covered under 42 CFR Part 495. (7-1-12)T

b. Provide the Medicaid EHR Incentive Program criteria for participation of qualified eligible professionals and hospitals that adopt, implement, or upgrade to become meaningful users of certified electronic health record systems in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA), Section 4201. (7-1-12)T

c. Provide for the audit of providers receiving incentive payments. (7-1-12)T

002. WRITTEN INTERPRETATIONS.
In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection at the location identified under Subsection 005.06 of these rules and in accordance with Section 006 of these rules. (7-1-12)T

003. ADMINISTRATIVE APPEALS.
All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (7-1-12)T

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference 42 CFR Part 495, "Medicare and Medicaid Programs," revised October 1, 2011. A hardcopy is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at: http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5.pdf. (7-1-12)T

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- TELEPHONE NUMBER -- INTERNET WEBSITE.

01. Office Hours. Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the State of Idaho. (7-1-12)T

02. Mailing Address. The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (7-1-12)T

03. Street Address. The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (7-1-12)T

04. Telephone. The telephone number for the Idaho Department of Health and Welfare is (208) 334-5500. (7-1-12)T

05. Internet Website. The Department's internet website is found at http://www.healthandwelfare.idaho.gov. (7-1-12)T

06. Division of Medicaid. The Department's Division of Medicaid is located at 3232 Elder Street, Boise, ID 83705; Phone: (208) 334-5747. (7-1-12)T

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT REQUESTS.

01. Confidentiality of Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." (7-1-12)T

02. Public Records Act. The Department will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. (7-1-12)T

007. -- 009. (RESERVED).

010. DEFINITIONS AND ABBREVIATIONS.

For the purposes of this chapter of rules the following terms apply: (7-1-12)T

01. Acute Care Hospital. A health care facility, including a critical access hospital, with a CMS Certification Number that ends in 0001-0879 or 1300-1399. An acute care hospital: (7-1-12)T

a. Must have ten percent (10%) Medicaid patient discharges; (7-1-12)T

b. Is a primary health care facility where the average length of patient stay is twenty-five (25) days or fewer. (7-1-12)T

02. Adopt, Implement, or Upgrade (AIU). (7-1-12)T

a. Acquire, purchase, or secure access to certified EHR technology; (7-1-12)T

b. Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or (7-1-12)T

c. Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology. (7-1-12)T

03. Attestation. Signature as a witness by each professional or hospital who applies to the EHR program signifying the information they have provided is true and genuine and affirms that they meet the EHR incentive payment eligibility criteria. (7-1-12)T

04. Border States. The border states for Idaho are: Washington, Oregon, Nevada, Utah, Wyoming, and Montana. (7-1-12)T

05. Certified EHR Technology. As defined in 42 CFR Section 495.4 (2010) and 45 CFR Section 170.102 (2010 and 2011), in accordance with the Office of the National Coordinator for Health Information Technology EHR certification criteria. (7-1-12)T

06. Children's Hospital. As referenced in 42 CFR Section 495.302, a separately certified hospital, either freestanding or hospital-within-hospital, that has a CMS Certification Number that ends in 3300–3399 and predominantly treats individuals under twenty-one (21) years of age. (7-1-12)T

07. CMS. Centers for Medicare and Medicaid Services. (7-1-12)T

08. Critical Access Hospital (CAH). A small, generally geographically remote facility that provides outpatient and inpatient hospital services to people in rural areas. The designation was established by law, for special payments under the Medicare program. A critical access hospital: (7-1-12)T

a. Is located in a rural area and provides 24-hour emergency services; (7-1-12)T

b. Has an average length-of-stay for its patients of ninety-six (96) hours or less; (7-1-12)T

c. Is located more than thirty-five (35) miles (or more than fifteen (15) miles in areas with mountainous terrain) from the nearest hospital or is designated by the State as a "necessary provider"; and (7-1-12)T

d. Has no more than twenty-five (25) beds. (7-1-12)T

09. CY. Calendar Year. (7-1-12)T

10. Dentist. A person who meets all the applicable requirements to practice as a licensed dentist under IDAPA 19.01.01, "Rules of the Idaho State Board of Dentistry." (7-1-12)T

11. Department. The Idaho Department of Health and Welfare. (7-1-12)T

12. **EHR**. Electronic Health Record. (7-1-12)T

13. **Eligible Hospital**. An acute care hospital with at least ten percent (10%) Medicaid patient volume or a children's hospital. (7-1-12)T

14. **Eligible Professional**. A physician, dentist, nurse practitioner (including a nurse-midwife nurse practitioner), or a physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is led by a physician assistant and meets patient volume requirements described in 42 CFR Section 495.306. (7-1-12)T

15. **Eligible Provider**. Eligible hospital or eligible professional. (7-1-12)T

16. **Eligible Provider, Hospital-Based**. In accordance with 42 CFR Section 495.4, an eligible provider who furnishes ninety (90) percent or more of his or her covered professional services in a hospital setting in the CY preceding the payment year. A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital, or emergency room setting. (7-1-12)T

17. **Encounter**. (7-1-12)T

a. For an eligible hospital either may apply: (7-1-12)T

i. Services rendered to an individual per inpatient discharge; or (7-1-12)T

ii. Services rendered to an individual in an emergency department on any one (1) day; (7-1-12)T

b. For an eligible professional, services rendered to an individual on any one (1) day. (7-1-12)T

18. **Enrolled Provider**. A hospital or health care practitioner who is actively registered with the Department's Idaho Medicaid EHR Incentive Program. (7-1-12)T

19. **Federal Fiscal Year (FFY)**. The federal fiscal year is from October 1 to September 30. (7-1-12)T

20. **Federally Qualified Health Center (FQHC)**. A federal designation for a medical entity that meets the requirements of 42 U.S.C. Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. (7-1-12)T

21. **Hospital-Based**. An eligibility criterion that excludes an eligible professional from participating in the Medicaid EHR Incentive Program when an eligible professional furnishes 90 percent (90%) or more of the eligible professional's Medicaid covered services in a hospital emergency room (place of service code 23), or inpatient hospital (place of service code 21) in the CY preceding the payment year. (7-1-12)T

22. **Meaningful EHR User**. An eligible provider that, for an EHR reporting period for a payment year, demonstrates (in accordance with 42 CFR Section 495.8) meaningful use of certified EHR technology by meeting the applicable objectives and associated measures in 42 CFR Section 495.6 and as prescribed by 42 CFR Part 495. (7-1-12)T

23. **Nurse Practitioner (NP)**. A licensed professional nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing," and as defined in 42 CFR Section 440.166. (7-1-12)T

24. **Payment Year**. (7-1-12)T

a. The CY for an eligible professional; or (7-1-12)T

b. The FFY for an eligible hospital. (7-1-12)T

25. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a State or United States territory, and who performs services as defined in 42 CFR Section 440.50. (7-1-12)T

26. Physician Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," and who performs services as defined in 42 CFR Section 440.60. (7-1-12)T

011. -- 099. (RESERVED).

ELIGIBILITY DETERMINATION
(Sections 100 through 399)

100. ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM ELIGIBILITY.

01. Providers and Hospitals Eligible to Participate in the EHR Incentive Program. The Department administers the federal EHR Incentive Program that pays incentive payments to eligible providers and eligible hospitals that adopt, implement, upgrade, and meaningfully use certified EHR technology in accordance with the provisions of 42 CFR Part 495. Providers and hospitals eligible to participate in the EHR incentive program are identified in 42 CFR Section 495.304. (7-1-12)T

02. Department Reviewing and Auditing of EHR Incentive Program Participants. As authorized by 42 CFR Part 495, the Department reviews and audits all professionals and hospitals participating in the EHR incentive program. The Department reviews all practice, documentation, and data related to the EHR technology to determine whether professionals and hospitals participating in the EHR incentive program are eligible and complying with the state and federal rules and regulations. The Department will be reviewing and auditing the EHR program. EHR program participants must meet the following requirements: (7-1-12)T

a. Patient volume thresholds and calculations, as outlined in 42 CFR Sections 495.304 and 495.306. (7-1-12)T

b. Eligibility criteria and payment limitations, as outlined in 42 CFR Sections 495.10, 495.304, 495.306, 495.308, and 495.310. (7-1-12)T

c. Attestations and compliance demonstrations including, at a minimum: (7-1-12)T

(i) Attestations that certified EHR technology has been adopted, implemented, or upgraded; and (7-1-12)T

(ii) Demonstrations of meaningful use, as outlined in 42 CFR Sections 495.6 and 495.8. (7-1-12)T

d. The payment process and incentive payment amounts, as outlined in 42 CFR Sections 495.310, 495.312, 495.314, and 495.316. (7-1-12)T

e. Additional issues regarding EHR incentive payments program eligibility, participation, documentation, and compliance as outlined in 42 CFR Part 495. (7-1-12)T

101. -- 199. (RESERVED).

200. EHR: FEDERALLY INITIATED PROGRAM.

01. Voluntary Federal Program. The EHR Incentive Program is a federal program, using federal funding, and is voluntary for providers. The Department has no obligation to pay incentive payments to the provider once federal funding is exhausted. (7-1-12)T

02. Idaho Sanctions/Outstanding Debt. (7-1-12)T

a. To be eligible for incentive payments, providers must be free of both state and federal level sanctions and exclusions as provided in Section 56-209h, Idaho Code, IDAPA 16.05.07, and 42 CFR Part 455. Providers who are on either the Idaho Medicaid Provider Exclusion List (http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/ProviderExclusionList.pdf) or on the federal List of Excluded Individuals/Entities (http://exclusions.oig.hhs.gov/) are not eligible to participate in the EHR Incentive Program. (7-1-12)T

b. The Department will reference the Idaho State Sanctions and the Outstanding Debt-Termination Exclusion Lists. Federal level checks with the Office of the Inspector General (OIG) will be conducted through the Idaho Incentive Management System (IIMS) and CMS interface. (7-1-12)T

c. Detection for improper payment will be conducted both at the state program level and at the federal level, as referenced in 42 CFR Sections 495.368(a)(1)(i) & (ii). (7-1-12)T

201. -- 299. (RESERVED).

300. EHR: ADDITIONAL PROVIDER QUALIFICATIONS.

01. Out-of-State Professionals and Hospitals. EHR incentive payments will be made only to Idaho Medicaid providers (professionals with an Idaho Medicaid Provider Agreement), unless they predominantly practice in an RHC or FQHC that is an Idaho Medicaid provider. (7-1-12)T

02. Patient Volume Calculation. Encounters for out-of-state Medicaid members (Border States only) may be included in the patient volume calculation only if needed to meet patient volume threshold. Out-of-state encounters must then be included in the numerator and the denominator of the patient volume calculation. (7-1-12)T

03. Eligible Professionals (EP) Licensure. The Department will consider a provisional license the same as licenses. (7-1-12)T

300. -- 399. (RESERVED).

400. STATE OPTIONS ELECTIONS UNDER THE EHR INCENTIVE PROGRAM.
In addition to the federal provisions in the ARRA, Section 4201, the Idaho EHR incentive program is governed by federal regulations at 42 CFR Part 495. In compliance with the requirements of federal law, the Department establishes the following State options under the Idaho EHR incentive program: (7-1-12)T

01. Calculating Patient Volume. For purposes of calculating patient volume as required by 42 CFR Section 495.306, the Department has elected eligible professionals and eligible hospitals to use 42 CFR Section 495.306(c). (7-1-12)T

02. Patient Volume Methodology. For eligible professionals who use a group proxy patient volume methodology outlined in 42 CFR Section 495.306(h), the EP must see at least one (1) Medicaid or medically underserved patient before he may apply for a Medicaid EHR incentive payment. (7-1-12)T

03. Hospital Fiscal Year. The twelve (12) month period defined by a hospital for financial reporting purposes that will be used to comply with 42 CFR Section 495.310(g)(1)(i)(B). (7-1-12)T

04. Determination of Hospital-Based. In accordance with 42 CFR Section 495.4(2)(ii)(B), in order to distinguish "hospital-based eligible professional" from "eligible professional (EP)" during the program year, the Department reviews the quantity and place of services rendered for the CY preceding the program year to which the payment will apply. (7-1-12)T

401. -- 999. (RESERVED)