

Dear Senators HEIDER, Souza, Jordan, and  
Representatives WOOD, Packer, Chew:

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

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1702);

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1703);

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1706);

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1707).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 11/13/2017. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 12/12/2017.

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 334-4834, or send a written request to the address on the memorandum attached below.



Eric Milstead  
Director

# Legislative Services Office

## Idaho State Legislature

*Serving Idaho's Citizen Legislature*

### MEMORANDUM

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

**FROM:** Senior Legislative Research Analyst - Elizabeth Bowen

**DATE:** October 24, 2017

**SUBJECT:** Department of Health and Welfare

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1702)

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1703)

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1706)

IDAPA 16.03.10 - Medicaid Enhanced Plan Benefits - Proposed Rule (Docket No. 16-0310-1707)

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.10, regarding Medicaid Enhanced Plan benefits.

Docket No. 16-0310-1702

This rule updates the existing rule to comply with federal regulations providing that access to mental health care services shall not be more restrictive than access to medical or surgical services. Negotiated rulemaking was conducted, and there is no anticipated negative fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

Docket No. 16-0310-1703

This rule is intended to streamline Medicaid program processes in order to improve patient access to early intervention services. Negotiated rulemaking was conducted, and there is no anticipated negative fiscal impact on the state general fund. The Department states that this rulemaking is authorized pursuant to several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

Docket No. 16-0310-1706

This rule establishes provisions regarding the Youth Empowerment Services (YES) program for children with serious emotional disturbance, pursuant to the Jeff D settlement agreement and House Bill 43, enacted by the 2017 Legislature. Provisions include:

- Definitions;
- A requirement that YES program participants be re-evaluated for eligibility every 12 months; and
- Descriptions of covered services, including respite care.

Negotiated rulemaking was not conducted due to the nature of the rule, which is to comply with a settlement agreement. There is no anticipated negative fiscal impact on the state general fund associated with the rulemaking; however, the costs of the program were estimated in the fiscal note to House Bill 43, and the Department has included a revised fiscal impact estimate in this docket. The Department states that this rulemaking is authorized pursuant to several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

Docket No. 16-0310-1707

Pursuant to the Jeff D settlement agreement, this rule implements a new assessment tool to determine eligibility for Medicaid developmental disability and related matters. References to an assessment tool that will no longer be used are removed. Negotiated rulemaking was not conducted due to the nature of the rule, which is to comply with the settlement agreement. The anticipated fiscal impact to the state general fund to implement the new assessment tool is \$261,335, which was appropriated by the 2017 Legislature. The Department states that this rulemaking is authorized pursuant to several sections of the Idaho Code, including Section 56-202, which authorizes rulemaking for public assistance programs.

cc: Department of Health and Welfare  
Beverly Barr and Frank Powell

**IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE**

**16.03.10 – MEDICAID ENHANCED PLAN BENEFITS**

**DOCKET NO. 16-0310-1702**

**NOTICE OF RULEMAKING – PROPOSED RULE**

**AUTHORITY:** In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, and 42 CFR Sections 438, 440, and 457.

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

**PUBLIC HEARING**

**Friday, October 13, 2017 — 2:00 p.m. (Local)**

**Central Idaho - DHW Office  
3232 Elder Street  
Conference Room D - East  
Boise, ID 83705**

**TELECONFERENCE CALL-IN**

**Toll Free: 1-877-820-7831  
Participant Code: 701700**

The hearing site 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:

Under the Code of Federal Regulations (CFR) sections cited above, access to mental healthcare services cannot be more restrictive than access for medical/surgical services. These rule changes allow the Department flexibility to adjust requirements for authorizations and coverage to ensure that access to mental health services is consistent with the requirements in CFR.

Specifically, inpatient psychiatric stays will be permitted for as long as they are medically necessary, and will be subject to the same reviews as general hospital stays. Participant eligibility for inpatient psychiatric stays are being defined to align with CFR restrictions. General hospital procedural guidelines are being changed to provide a psychiatric services structure with which to align. General hospital inpatient provisions are being changed to match current Medicaid practice and Centers for Medicare and Medicaid Services (CMS) requirements. Finally, under physician services, limitations for psychiatric evaluations and psychotherapy are being removed. Should the Department need to make adjustments to remain in compliance with federal requirements or to maintain appropriate utilization of services in the future, these changes will allow for modification for those needs.

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

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

The fiscal impact associated with this rule change is minimal to none. An analysis conducted by the Division of Medicaid concluded any potential impact is so minimal that requesting additional funds is not warranted at this time.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2017, Idaho Administrative Bulletin, **Vol. 17-6, pages 39 and 40.**

**INCORPORATION BY REFERENCE:** No materials are being incorporated by reference in this rulemaking.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact William Deseron at (208) 364-1967.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

Tamara Prisock  
DHW - Administrative Rules Unit  
450 W. State Street - 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
Phone: (208) 334-5500 / Fax: (208) 334-6558  
E-mail: [dhwrules@dhw.idaho.gov](mailto:dhwrules@dhw.idaho.gov)

**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1702  
(Only Those Sections With Amendments Are Shown.)**

**SUB AREA: ENHANCED INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES  
(Sections 100 - 199)**

**100. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES.**

*In addition to The Medicaid Enhanced Plan Benefits include psychiatric services covered under inpatient hospital services and inpatient ~~psychiatric hospital~~ behavioral health services covered in IDAPA 16.03.09 "Medicaid Basic Plan Benefits," ~~the Medicaid Enhanced Plan Benefit include enhanced medically necessary services for certain individuals under the age of twenty one (21) in free standing psychiatric hospitals (Institutions For Mental Disease);~~ (3-19-07)(    )*

~~101. (RESERVED)~~

**1021. INPATIENT ~~PSYCHIATRIC HOSPITAL~~ BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.**

All rules in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 700 through 707~~6~~ apply to Inpatient ~~Psychiatric Hospital~~ Behavioral Health ~~s~~Services in this chapter of rules. Individuals over age sixty-five (65) are eligible for inpatient behavioral health services under this chapter of rule. (3-19-07)(    )

~~01. **Limitation Exemption.** The ten (10) day limitation does not apply to participants who are eligible for inpatient psychiatric hospital services under this chapter of rule. (3-19-07)~~

~~02. **Individuals Over 65.** Individuals over age sixty-five (65) are eligible for inpatient psychiatric hospital services under this chapter of rule. (3-19-07)~~

~~1032. -- 199. (RESERVED)~~

# **IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE**

## **16.03.10 – MEDICAID ENHANCED PLAN BENEFITS**

**DOCKET NO. 16-0310-1703**

### **NOTICE OF RULEMAKING – PROPOSED RULE**

**AUTHORITY:** In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

#### **PUBLIC HEARING**

**Tuesday, October 17, 2017 — 2:00 p.m. (Local)**

**Central Idaho - DHW Office  
3232 Elder Street  
Conference Room D - East  
Boise, ID 83705**

#### **TELECONFERENCE CALL-IN**

**Toll Free: 1-877-820-7831  
Participant Code: 626553**

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

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

The Department's Infant Toddler and Medicaid programs are both required by federal law to provide access and reimbursement for early intervention services. This rule change is needed to streamline the processes between two Department Divisions and to resolve the current access issue. Currently, the Infant Toddler Program has a waiting list of children, including Medicaid-eligible children, that are unable to access Part C, early intervention treatment services. This change will keep the State in compliance in both areas, provide a more streamlined approach between the two Divisions, and will ensure improved access to these services for participants.

Early intervention service requirements will be removed from this chapter and added as a new Section in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." The rule text will be updated to support program eligibility, service coverage, limitations, provider, and reimbursement requirements. These changes will allow the Department more flexibility for collaboration within IDHW Divisions and ensure all Medicaid-eligible infants and toddlers receive the right preventive services, at the right time, through the best financial means for the State. Updates to references or other minor technical corrections may be made as needed.

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

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

This proposed change impacts the Division of Medicaid and the Division of Family and Community Services. Currently both divisions support these services for children with special healthcare needs from birth through the end of their 36th month of age through a combination of a federal grant and Medicaid benefits payments.

This rule will enable additional Medicaid coverage for these services, which will allow leveraging federal funds to support better services for Idaho. There is no overall impact to the general fund; however, a transfer of general funds between divisions will be necessary. In addition, the FACS division will require an increase of \$1,129,800 in federal spending authority and will revert \$1,126,700 in receipt spending authority.

The net impact will increase federal expenditures for these services but will not increase the general fund needs. This will allow us to increase services to children and use state general funds more efficiently.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the June 7, 2017, Idaho Administrative Bulletin, [Vol. 17-6, page 41](#).

**INCORPORATION BY REFERENCE:** No materials are being incorporated by reference in this rulemaking.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Cindy Brock at (208) 364-1983.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

Tamara Prisock  
DHW - Administrative Rules Unit  
450 W. State Street - 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
Phone: (208) 334-5500 / Fax: (208) 334-6558  
E-mail: [dhwrules@dhw.idaho.gov](mailto:dhwrules@dhw.idaho.gov)

**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1703**  
**(Only Those Sections With Amendments Are Shown.)**

**660. CHILDREN'S HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION.**

In accordance with [Section](#) 1915i of the Social Security Act, the Department will pay for home and community based services provided by individuals or agencies that have entered into a provider agreement with the Department. Services provided by a developmental disabilities agency ~~or the Infant Toddler Program~~ to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. ~~(7-1-13)~~( )

**661. CHILDREN'S HCBS STATE PLAN OPTION: DEFINITIONS.**

For the purposes of these rules, the definitions in Section 521 of these rules apply. Additionally, the following terms apply to the Children's Home and Community Based Services State Plan Option: (7-1-11)

**01. Agency.** A developmental disabilities agency (DDA) as defined in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (7-1-11)

**02. Annual.** Every three hundred sixty-five (365) days except during a leap year which equals three hundred sixty-six (366) days. (7-1-11)

**03. Clinical Supervisor.** For the purposes of these rules, the clinical supervisor is the professional responsible for the supervision of DDA staff as outlined in IDAPA 16.03.21, “Developmental Disabilities Agencies (DDA);” ~~or is the professional responsible for the child's IFSP as designated by the Infant Toddler Program.~~ (7-1-13)(    )

**04. Community.** Natural, integrated environments outside of the home, school, or DDA center-based settings. (7-1-11)

**05. Developmental Disabilities Agency (DDA).** A DDA is an agency that is: (7-1-11)

**a.** A type of developmental disabilities facility, as defined in Section 39-4604(7), Idaho Code, that is non-residential and provides services on an outpatient basis; (7-1-11)

**b.** Certified by the Department to provide home and community based services to people with developmental disabilities, in accordance with these rules; (7-1-11)

**c.** A business entity, open for business to the general public; and (7-1-11)

**d.** Primarily organized and operated to provide home and community based services and the corresponding assessments to people with developmental disabilities. DDA services include evaluations, diagnostic, treatment, and support services that are provided on an outpatient basis to persons with developmental disabilities and may be community-based, home-based, or center-based in accordance with the requirements of this chapter. (7-1-11)

**06. Home and Community Based Services State (HCBS) Plan Option.** The federal authority under section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and individuals with disabilities, without determining that without the provision of services the individuals would require institutional level of care. (7-1-11)

**07. Human Services Field.** A particular area of academic study in health care, social services, education, behavioral science or counseling. (7-1-11)

~~**08. Infant Toddler Program.** The Infant Toddler Program serves children birth up to three (3) years of age (36 months), and must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include: adherence to procedural safeguards and time lines, use of multi-disciplinary assessments and Individualized Family Service Plans (IFSPs), provision of early intervention services in the natural environment, transition planning, and program enrollment and reporting requirements. (7-1-13)~~

**09. Integration.** The process of promoting a life for individuals with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having access to community resources. A further goal of this process is to enhance the social image and personal competence of individuals with developmental disabilities. (7-1-11)

**10. Paraprofessional.** A person qualified to provide direct support services which include respite and habilitative supports. (7-1-11)

**11. Professional.** A person qualified to provide direct intervention services which include habilitative intervention, therapeutic consultation, family education, family training, interdisciplinary training, and crisis intervention. (7-1-11)

**12. Support Services.** Support services may provide supervision for a participant, as well as may provide assistance to a participant by facilitating integration into the community. (7-1-11)

(BREAK IN CONTINUITY OF SECTIONS)



664. CHILDREN'S HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

**01. General Requirements for Program Documentation.** The provider must maintain records for each participant served. Each participant's record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following program documentation is required: (7-1-11)

a. Direct service provider information that includes written documentation of the service provided during each visit made to the participant, and contains, at a minimum, the following information: (7-1-11)

i. Date and time of visit; and (7-1-11)

ii. Intervention and support services provided during the visit; and (7-1-11)

iii. A statement of the participant's response to the service; and (7-1-11)

iv. Length of visit, including time in and time out; and (7-1-11)

v. Specific place of service. (7-1-11)

vi. A copy of the above information will be maintained by the independent provider or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-11)

**02. Habilitative Supports Documentation.** In addition to the general requirements listed in Subsection 664.01 of this rule, the following must be completed: (7-1-11)

a. On a monthly basis, the habilitative support staff must complete a summary of the participant's response to the support service and submit the monthly summary to the clinical supervisor. (7-1-11)

b. The clinical supervisor reviews the summary on a monthly basis and when recommendations for changes to the type and amount of support are identified, submits the recommendations to the plan developer. (7-1-11)

**03. Family Education Documentation.** In addition to the general requirements listed in Subsection 664.01 of this rule, the DDA ~~or Infant Toddler Program~~ must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. (7-1-13)( )

**04. Reporting Requirements.** The clinical supervisor must complete at a minimum, six- (6) month and annual provider status reviews for habilitative support services provided. These provider status reviews must be completed more frequently, when so required on the plan of service. (7-1-11)

a. Documentation of the six- (6) month and annual reviews must be submitted to the plan monitor. (7-1-11)

b. The provider must use Department-approved forms for provider status reviews. (7-1-11)

665. CHILDREN'S HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES.

All providers of HCBS state plan option services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (7-1-11)

**01. Respite.** Respite services may be provided by an agency that is certified as a DDA and is capable of supervising the direct services provided, by an independent respite provider, ~~or by the Infant Toddler Program~~. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite services must meet the following minimum qualifications: (7-1-13)( )

a. Must be at least sixteen (16) years of age when employed by a DDA ~~or Infant Toddler Program~~; or (7-1-13)( )

- b. Must be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an independent respite provider; and (7-1-11)
- c. Meet the qualifications prescribed for the type of services to be rendered, or must be an individual selected by the participant, the family, or the participant's guardian; and (7-1-11)
- d. Have received instructions in the needs of the participant who will be provided the service; and (7-1-11)
- e. Demonstrate the ability to provide services according to a plan of service; and (7-1-11)
- f. Must satisfactorily complete a criminal history background check in accordance with IDAPA 16.05.06 "Criminal History and Background Checks"; and (7-1-11)
- g. When employed by a DDA ~~or Infant Toddler Program~~, 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 respite providers must be certified in CPR and first aid prior to delivering services, and must maintain current certification thereafter. (7-1-13)(      )

**02. Habilitative Support Staff.** Habilitative supports must be provided by an agency certified as a DDA with staff who are capable of supervising the direct services provided, ~~or by the Infant Toddler Program~~. Providers of habilitative supports must meet the following minimum qualifications: (7-1-13)(      )

- a. Must be at least eighteen (18) years of age; (7-1-11)
- b. Must be a high school graduate or have a GED; (7-1-11)
- c. Have received instructions in the needs of the participant who will be provided the service; (7-1-11)
- d. Demonstrate the ability to provide services according to a plan of service; (7-1-11)
- e. Must have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: (7-1-11)
  - i. Have previous work experience gained through paid employment, university practicum experience, or internship; or (7-1-11)
  - ii. Have on-the-job supervised experience gained through employment at a DDA ~~or the Infant Toddler Program~~ with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services, and a minimum of weekly face-to-face supervision with the clinical supervisor for a period of six (6) months while delivering services. (7-1-13)(      )
- f. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide habilitative supports. (7-1-11)
- g. In addition to the habilitative support qualifications listed in Subsections 665.02.a. through f. of this rule, habilitative support staff serving infants and toddlers from birth to three (3) years of age must meet the following qualifications: (7-1-11)
  - i. Have transcribed 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)
  - ii. 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)

**03. Family Education.** Family education must be provided by an agency certified as a DDA and with staff who are capable of supervising the direct services provided, ~~or by the Infant Toddler Program~~. Providers of family education must meet the following minimum qualifications: (7-1-13)

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

i. One (1) year experience providing care to children with developmental disabilities; (7-1-11)

ii. Must complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide family education; or (7-1-11)

**b.** Individuals working as Developmental Specialists for children ages birth through three (3) or three (3) through seventeen (17), and individuals certified as Intensive Behavioral Interventionist professionals prior to July 1, 2011, are qualified to provide family education 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)

**c.** Each professional providing family education 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 family education 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)

**04. Family Education for Children Birth to Three.** In addition to the family education qualifications listed in Subsections 665.03.a. through 665.03.c. of this rule, family education 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 665.04.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 665.04.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. 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 Section 685 of these rules. Clinical supervisor(s) are professionals employed by a DDA ~~or the Infant Toddler Program~~ on a continuous and regularly scheduled basis. (7-1-13)(      )

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 ~~and the Infant Toddler Program~~ must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. (7-1-13)(      )

**06. Requirements for Collaboration.** Providers of home and community based services must coordinate with the family-centered planning team as specified on the plan of service. (7-1-11)

**07. Requirements for Quality Assurance.** Providers of children's home and community based state plan option services must demonstrate high quality of services through an internal quality assurance review process. (7-1-11)

**08. DDA Services.** In order for a DDA to provide respite, habilitative supports, and family education the DDA must be certified to provide support services. Each DDA is required to provide habilitative supports. (7-1-11)

**(BREAK IN CONTINUITY OF SECTIONS)**

**680. CHILDREN'S WAIVER SERVICES.**

**01. Purpose of and Eligibility for Waiver Services.** Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible children to prevent unnecessary institutional placement, provide for the greatest degree autonomy and of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs his mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/ID. (7-1-16)

**02. Waiver Services Provided by a DDA ~~or the Infant Toddler Program~~.** Services provided by a developmental disabilities agency ~~or the Infant Toddler Program~~ to children birth to three (3) years of age must meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C; the Family Education Rights and Privacy Act; Sections 16-101, et seq., Idaho Code, regarding early intervention services; and the Idaho State Plan for Early Intervention Services under IDEA, Part C. These requirements include adherence to procedural safeguards and time lines, multi-disciplinary assessments, evaluations, individualized family service plans, provision of early intervention services in the natural environment, transition planning, and enrollment and reporting requirements. (7-1-13)(    )

**(BREAK IN CONTINUITY OF SECTIONS)**

**684. CHILDREN’S WAIVER SERVICES: PROCEDURAL REQUIREMENTS.**

**01. Authorization of Services on a Written Plan.** All children’s waiver services must be identified on the plan of service and authorized by the Department. The plan of service must be reviewed by a plan developer at least every six (6) months or at a frequency determined by the family-centered planning team. (7-1-11)

**02. General Requirements for Program Documentation.** Children’s waiver providers must maintain records for each participant the agency serves. Each participant’s record must include documentation of the participant’s involvement in and response to the services provided. For each participant the following program documentation is required: (7-1-11)

**a.** Direct service provider information which includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: (7-1-11)

i. Date and time of visit; and (7-1-11)

ii. Services provided during the visit; and (7-1-11)

iii. A statement of the participant’s response to the service, including any changes in the participant’s condition; and (7-1-11)

iv. Length of visit, including time in and time out; and (7-1-11)

v. Specific place of service. (7-1-11)

**b.** A copy of the above information ~~will~~ **must** be maintained by the independent provider, ~~Infant Toddler Program~~, or DDA. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (7-1-13)(    )

**03. Program Implementation Plan Requirements.** For each participant receiving intervention and family training services, the DDA ~~or the Infant Toddler Program~~ must develop a program implementation plan to determine objectives to be included on the participant’s required plan of service. (7-1-13)(    )

**a.** All program implementation plan objectives must be related to a goal on the participant’s plan of service. (7-1-11)

**b.** The program implementation plan must be written, implemented, and submitted to the plan developer within fourteen (14) days after the first day of ongoing programming and be revised whenever participant needs change. If the program implementation plan is not completed within this time frame, the participant's records must contain documented participant-based justification for the delay. (7-1-13)

**c.** The program implementation plan must be completed by the habilitative interventionist, and must include the following requirements: (7-1-11)

i. The participant's name. (7-1-11)

ii. A baseline statement. (7-1-11)

iii. Measurable, behaviorally-stated objectives that correspond to those goals or objectives previously identified on the required plan of service. (7-1-11)

iv. Written instructions to the staff that may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. (7-1-11)

v. Identification of the type of environment(s) and specific location(s) where services will be provided. (7-1-11)

vi. A description of the evidence-based treatment approach used for the service provided. (7-1-11)

vii. When the child has a current positive behavior support plan, it must be incorporated into the program implementation plan. (7-1-11)

viii. When interdisciplinary training is provided, identification of the type of interdisciplinary training and the objectives related to the training must be included on the program implementation plan. (7-1-11)

ix. Target date for completion, not to exceed one (1) year. (7-1-11)

x. The program implementation plan must be reviewed and approved by the clinical supervisor, as indicated by signature, credential, and date on the plan. (7-1-13)

**04. Reporting Requirements.** The clinical supervisor must complete, at a minimum, six- (6) month and annual provider status reviews for habilitative intervention and family training services provided. These provider status reviews must be completed more frequently when so required on the plan of service. (7-1-11)

**a.** Documentation of the six (6) month and annual reviews must be submitted to the plan developer. (7-1-11)

**b.** The provider must use Department-approved forms for provider status reviews. (7-1-11)

**05. Provider Responsibility for Notification.** It is the responsibility of the service provider to notify the plan developer when any significant changes in the participant's condition, as defined by the family-centered planning team, are noted during service delivery. Such notification will be documented in the service record. (7-1-11)

**06. Records Maintenance.** When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. (7-1-11)

**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* The DDA must be capable of supervising the direct services provided, ~~or by the Infant Toddler Program.~~ Providers of habilitative intervention must meet the following minimum qualifications: (7-1-13)(    )

**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 685.03.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 Agencies (DDA)," or by an independent Medicaid provider under agreement with the Department, ~~or by the Infant Toddler Program.~~ Providers of therapeutic consultation must meet the following minimum qualifications: (7-1-13)(    )
- 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 ~~or the Infant Toddler Program~~ 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. ~~(7-1-13)~~( )

**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),” by an independent Medicaid provider under agreement with the Department, ~~or by the Infant Toddler Program~~. Providers of crisis intervention must meet the following minimum qualifications: ~~(7-1-13)~~( )

**a.** Crisis Intervention professionals must meet the minimum therapeutic consultation provider qualifications described in Subsection 685.05 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 DD 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 ~~or the Infant Toddler Program~~ on a continuous and regularly scheduled basis. ~~(7-1-13)~~( )

**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 ~~and the Infant Toddler Program~~ must employ an adequate number of clinical supervisors to ensure quality service delivery and participant satisfaction. ~~(7-1-13)~~( )

**09. Requirements for Collaboration with Other Providers.** 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 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. (3-20-14)

**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)

# **IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE**

## **16.03.10 – MEDICAID ENHANCED PLAN BENEFITS**

**DOCKET NO. 16-0310-1706**

### **NOTICE OF RULEMAKING – PROPOSED RULE**

**AUTHORITY:** In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code; House Bill 43 (2017); and Section 1915(i) of the Social Security Act (42 U.S.C. 1396n).

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

**PUBLIC HEARING**  
**Wednesday, October 18, 2017 — 9:00 a.m. (Local)**

**Central Idaho - DHW Office**  
**3232 Elder Street**  
**Conference Room D - East**  
**Boise, ID 83705**

The hearing site 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:

As part of the Jeff D settlement agreement and the adoption of HB 43 (2017) which is directly related to it, the Department has created the Youth Empowerment Services (YES) program for children with Serious Emotional Disturbance (SED). The YES program will provide medical and behavioral health assistance to this target population, including respite care. These rule changes are needed so that the Department can provide these services to YES Program participants in accordance with the Jeff D settlement agreement.

This rulemaking adds new sections of rules to administer services and supports to be delivered under 1915(i) authority as a Medicaid state plan option. This will include the service of respite care. (Section 1915(i) of the Social Security Act gives states the option to offer home and community-based services (HCBS), previously available only through a 1915(c) Home and Community Based Services (HCBS) waiver, through the state's Medicaid state plan.)

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

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

The costs for the Youth Empowerment Services (YES) program were originally estimated in the fiscal note for House Bill 43 (2017) and funding was addressed in House Bill 313 (2017).

A revised version of this fiscal note is presented in the following paragraph:

This rulemaking will have no impact to the State General Fund, but will have a federal fund spending authority impact of \$2,968,400 in the Division of Medicaid for the last 6 months of SFY 2018. The Division of Behavioral Health's Children's Mental Health program reverted \$1,181,600 General Fund for services that do not draw a federal match in SFY 2018 under House Bill 313. The Division of Medicaid will leverage matching federal funds through Federal Medical Assistance Percentage (FMAP) funding. In future years, as additional services are implemented as required by the lawsuit settlement agreement, there is an anticipated annual ongoing cost of \$8,300,000 (\$2,363,200 General Fund/\$5,936,800 federal funds).

In addition to the above fiscal impact, Rule Docket 16-0318-1701 in the 2018 legislative session is bringing forward sliding scale premiums for participants with income levels above 150% of the Federal Poverty Guidelines, as

directed under HB 313 in the 2017 legislative session. It is anticipated that revenue generated through premium collections will also contribute to offsetting the fiscal impact of the implementation of these services.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because negotiated rulemaking was not feasible since these rule changes are not negotiable as the benefits included herein are court-ordered through the Jeff D settlement agreement.

**INCORPORATION BY REFERENCE:** No materials are being incorporated by reference in this rulemaking.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Clay Lord at (208) 364-1979.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

Tamara Prisock  
DHW - Administrative Rules Unit  
450 W. State Street - 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
Phone: (208) 334-5500 / Fax: (208) 334-6558  
E-mail: [dhwrules@dhw.idaho.gov](mailto:dhwrules@dhw.idaho.gov)

**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1706**  
**(Only Those Sections With Amendments Are Shown.)**

634. ~~644.~~ (RESERVED)

**YOUTH EMPOWERMENT SERVICES (YES) HOME AND COMMUNITY-BASED SERVICES (HCBS)**  
**STATE PLAN OPTION**  
**(Sections 635-638)**

**635. YOUTH EMPOWERMENT SERVICES (YES) HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION.**

Home and community-based services are provided through the HCBS State Plan option, as allowed in Section 1915(i) of the Social Security Act, for children who are YES program participants. HCBS state plan option services must be delivered in accordance with Sections 635 through 638 of these rules. ( )

**636. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: DEFINITIONS.**

For the purposes of Sections 635 through 638 of these rules, the following terms are used as defined below. ( )

**01. Idaho Behavioral Health Plan (IBHP).** The Idaho Behavioral Health Plan is defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 011. ( )

**02. Independent Assessment.** A comprehensive clinical diagnostic assessment and a Department-approved assessment tool to identify the child's needs, strengths, and degree of functional impairment, administered by a Department-designated independent assessor. The assessment process also includes the following activities: ( )

a. Evaluation of the child’s current behavioral health, living situation, relationships, and family functioning: ( )

b. Contacts, as necessary, with significant individuals such as family and teachers; and ( )

c. A review of information regarding the child’s clinical, educational, social, and behavioral health, and juvenile/criminal justice history. ( )

03. **Person-centered Service Plan.** The person-centered service plan identifies the participant’s physical and behavioral health services and supports needs. The person-centered service plan must be reviewed and updated by the Department or its designated representative at least every twelve (12) months, upon the participant’s request, when new services are needed, or when there is a significant change in the participant’s condition. ( )

04. **Serious Emotional Disturbance (SED).** The term “serious emotional disturbance” is defined in Section 16-2403, Idaho Code. ( )

05. **YES Program Participant.** A YES program participant is an Idaho resident under eighteen (18) years of age with a serious emotional disturbance as determined by an independent assessment. ( )

637. **YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: ELIGIBILITY REDETERMINATION.** YES program participant eligibility must be redetermined by an independent assessment every twelve (12) months. The Department may extend participant eligibility to allow for redetermination if the independent assessment is unavoidably delayed. ( )

638. **YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.** The following services are covered for YES participants: ( )

01. **Respite Care.** Respite care provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver of a YES program participant. Respite care is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Payment and administration of respite care services will be done through the IBHP and will be established by the Department in the IBHP contract. ( )

02. **Person-Centered Planning.** A person-centered planning team, comprised of the participant, family members, and other support persons significant to the participant, will direct the development of the person-centered service plan through a process approved by the Department. The process will include support necessary to enable the participant and his family to make informed choices and decisions concerning the person-centered service plan. ( )

639. -- 644. **(RESERVED)**

**IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE**

**16.03.10 – MEDICAID ENHANCED PLAN BENEFITS**

**DOCKET NO. 16-0310-1707**

**NOTICE OF RULEMAKING – PROPOSED RULE**

**AUTHORITY:** In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, and 56-260 through 56-266, Idaho Code.

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

**PUBLIC HEARING**

**Monday, October 23, 2017 — 3:00 p.m. (MDT)**

**Medicaid Central Office  
3232 Elder Street  
Conference Room D - West/East  
Boise, ID 83705**

**TELECONFERENCE CALL-IN**

**Toll Free: 1-877-820-7831  
Participant Code: 301388**

The hearing site 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:

Under a court-approved settlement agreement, the Department is implementing the use of a new assessment tool to replace the SIB-R assessment tool. The Department uses assessment tools to determine developmental disability eligibility, waiver eligibility, skill level, and the participant’s budget for services. Reference to the SIB-R assessment tool is being removed from this chapter and will no longer be incorporated by reference. The Department-approved assessment tool is being defined in the chapter and all references to the SIB-R will be removed and replaced throughout this chapter. Any manuals for new assessment tools being used by the Department are not being incorporated by reference. Other amendments to these rules are for updating terminology and references in these rules as needed.

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

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

The fiscal impact to implement and use a new assessment tool is a total of \$909,375. These costs are funded by 71.26% (\$648,020) federal funds and 28.74% (\$261,355) state general funds. The costs to the state were included in the SFY 2018 budget previously approved by the 2017 Legislature.

**NEGOTIATED RULEMAKING:** Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was not conducted. The Department determined it was not feasible to do negotiated rulemaking because the change is being made to comply with a court-approved settlement agreement.

**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: The SIB-R Comprehensive Manual is being deleted from the documents that are incorporated by reference in this chapter of rules.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Karen Westbrook at (208) 364.1960.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2017.

DATED this 1st day of September, 2017.

Tamara Prisock  
DHW - Administrative Rules Unit  
450 W. State Street - 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
Phone: (208) 334-5500  
Fax: (208) 334-6558  
E-mail: [dhwrules@dhw.idaho.gov](mailto:dhwrules@dhw.idaho.gov)

**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0310-1701**  
**(Only Those Sections With Amendments Are Shown.)**

**004. INCORPORATION BY REFERENCE.**

The Department has incorporated by reference the following document: (3-19-07)

**01. 42 CFR Part 447.** 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at [http://www.ecfr.gov/cgi-bin/text-idx?SID=3ec1965dbf5044d8f79b25d4d58c4cd1&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4\\_02.tpl#0](http://www.ecfr.gov/cgi-bin/text-idx?SID=3ec1965dbf5044d8f79b25d4d58c4cd1&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0). (3-19-07)

**02. CDT - 2007/2008 (Current Dental Terminology, Sixth Edition).** Current Dental Terminology, Sixth Edition, is available from the American Dental Association, 211 East Chicago Ave., Chicago, IL 60601-9985, or may be ordered online at <http://www.adacatalog.org>. A copy is available for public review at the Division of Medicaid, 3232 Elder Street, Boise, ID 83705. (5-8-09)

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

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

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

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

~~07. **SIB-R Comprehensive Manual.** Scales of Independent Behavior—Revised Comprehensive Manual, 1996, Riverside Publishing Co, 425 Spring Lake Drive, Itasca, IL 60143-2079. (3-19-07)~~

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

**(BREAK IN CONTINUITY OF SECTIONS)**

**503. DEVELOPMENTAL DISABILITY DETERMINATION: TEST INSTRUMENTS.**

A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. (3-19-07)

**01. Test Instruments For Adults.** ~~Unless contra indicated, the following test instruments or subsequent revisions~~ A Department-approved assessment tool for conducting cognitive and functional assessments must be used to determine eligibility. ~~(3-19-07)( )~~

~~a. Cognitive: Wechsler Adult Intelligence Scale-Third Edition (WAIS-III). (3-19-07)~~

~~b. Functional: Scales of Independent Behavior Revised (SIB-R). (3-19-07)~~

**02. Test Instruments for Children.** The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills. ~~Unless contraindicated, the most recent version of the following test instruments~~ A Department-approved assessment tool for conducting cognitive and functional assessments must be used with children. ~~(7-1-11)( )~~

~~a. Cognitive: (3-19-07)~~

~~i. Bayley Scales of Infant Development, for ages birth through forty-two (42) months; (7-1-11)~~

~~ii. Stanford Binet Intelligence Scales, for ages two (2) years through adult; (7-1-11)~~

~~iii. Wechsler Preschool and Primary Scale of Intelligence, for ages two (2) years, six (6) months to seven (7) years, three (3) months; (7-1-11)~~

~~iv. Wechsler Intelligence Scale for Children, for ages six (6) through sixteen (16) years, eleven (11) months; or (7-1-11)~~

~~v. Wechsler Adult Intelligence Scale, for ages sixteen (16) years to adult. (7-1-11)~~

~~b. Functional: (3-19-07)~~

~~i. Battelle Developmental Inventory, 2nd Edition (BDI-2) for ages birth to ninety-five (95) months; (3-19-07)~~

~~ii. Scales of Independent Behavior (SIB-R) for ages birth through adult; or (7-1-11)~~

- iii. ~~Mullen Scales of Early Learning (MSEL) for ages birth to three (3) years.~~ (7-1-11)

**(BREAK IN CONTINUITY OF SECTIONS)**

**508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.**

For the purposes of these rules the following terms are used as defined below. (3-29-12)

- 01. Adult.** A person who is eighteen (18) years of age or older. (3-29-10)
- 02. Assessment.** A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. (3-19-07)
- 03. Clinical Review.** A process of professional review that validates the need for continued services. (3-19-07)
- 04. Community Crisis Support.** Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. (3-19-07)
- 05. Concurrent Review.** A clinical review to determine the need for continued prior authorization of services. (3-19-07)
- 06. Department-Approved Assessment Tool.** Any standardized assessment tool approved by the Department for use in determining developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant's budget. ( )
- ~~067.~~ **Exception Review.** A clinical review of a plan that falls outside the established standards. (3-19-07)
- ~~078.~~ **Interdisciplinary Team.** For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. (3-19-07)
- ~~089.~~ **Level of Support.** An assessment score derived from ~~the SIB-R~~ a Department-approved assessment tool that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-19-07)( )
- ~~0910.~~ **Person-Centered Planning Process.** A meeting facilitated by the participant or plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (7-1-16)
- ~~101.~~ **Person-Centered Planning Team.** The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. (3-19-07)
- ~~112.~~ **Plan Developer.** A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. (3-19-07)
- ~~123.~~ **Plan Monitor.** A person who oversees the provision of services on a paid or non-paid basis. (3-19-07)
- ~~134.~~ **Plan of Service.** An initial or annual plan that identifies all services and supports based on a



person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days. (3-19-07)

**145. Prior Authorization (PA).** A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-19-07)

**156. Provider Status Review.** The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-19-07)

**167. Right Care.** Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-19-07)

**178. Right Place.** Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-19-07)

**189. Right Price.** The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-19-07)

~~190.~~ **Right Outcomes.** Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-19-07)

~~201.~~ **Service Coordination.** Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. (3-19-07)

~~212.~~ **Service Coordinator.** An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-19-07)

~~223.~~ **Services.** Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-19-07)

~~23.~~ **SIB-R.** *The Scales of Independent Behavior—Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department to determine developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget.* (3-19-07)

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

**509. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: ELIGIBILITY DETERMINATION.**

The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments must be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/ID level of care for waiver services in accordance with Section 584 of these rules. (3-29-12)

**01. Initial Assessment.** For new applicants, an assessment must be completed within thirty (30) days from the date a completed application is submitted. (3-19-07)

**02. Annual Assessments.** Assessments must also be completed for current participants at the time of their annual eligibility redetermination. The assessor must evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service: (3-19-07)

**a.** The assessment process must be completed; and (3-19-07)

- b. The assessor must provide the results of the assessment to the participant. (3-19-07)

**03. Determination of Developmental Disability Eligibility.** The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services must include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. A ~~SIB-R~~ Department-approved assessment tool will be administered by the Department for use in this determination. (~~3-19-07~~)(      )

**04. ICF/ID Level of Care Determination for Waiver Services.** The assessor will determine ICF/ID level of care for adults in accordance with Section 584 of these rules. (3-19-07)

**(BREAK IN CONTINUITY OF SECTIONS)**

**512. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.**

**01. Assessment for Plan of Service.** The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. (3-19-07)

**02. Physician's History and Physical.** The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: (3-29-10)

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. (3-19-07)

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. (3-19-07)

**03. Medical, Social, and Developmental History.** The medical, social and developmental history is used to document the participant's medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of developmental therapy and must be reviewed annually to assure it continues to reflect accurate information about the participant's status. (7-1-13)

a. A medical, social and developmental history for each adult participant is completed by the Department or its contractor. (7-1-13)

b. Providers should obtain and utilize the medical, social developmental history documents generated by the Department or its contractor when one is necessary for adult program or plan development. (7-1-13)

**04. ~~SIB-R~~ Department-Approved Assessment Tool.** The results of ~~the SIB-R~~ a Department-approved assessment tool are used to determine the level of support for the participant. A current ~~SIB-R~~ Department-approved assessment tool must be evaluated prior to the initiation of service and must be reviewed annually to assure it continues to reflect the functional status of the participant. ~~The SIB-R~~ A department-approved assessment tool for adults is completed by the Department or its contractor. Providers must obtain and utilize the document generated by the Department or its contractor when one is necessary for program or plan development. (~~7-1-13~~)(      )

**05. Medical Condition.** The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (3-19-07)

**06. Behavioral or Psychiatric Needs.** Behavioral or psychiatric needs that require special consideration. (3-19-07)

**(BREAK IN CONTINUITY OF SECTIONS)**

**514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.**

Providers are reimbursed on a fee for service basis based on a participant budget. (3-29-12)

**01. Individualized Budget Beginning on October 1, 2006.** Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-29-12)

**a.** The Department notifies each participant of his set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-29-12)

**b.** Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. (3-29-12)

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

**a.** High support is for those participants who require twenty-four (24) hour per day supports and supervision ~~and have an SIB-R Support Level of Pervasive, Extensive, or Frequent~~ **as determined by a Department-approved assessment tool.** High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (3-19-07)(    )

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

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

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

**iii.** Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person

makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-19-07)

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

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

- i. The participant is eligible to receive the high support daily rate; (3-19-07)
- ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-19-07)
- iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and (3-19-07)
- iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-19-07)

**(BREAK IN CONTINUITY OF SECTIONS)**

**584. ICF/ID: CRITERIA FOR DETERMINING ELIGIBILITY.**

Individuals who have intellectual disabilities or a related condition as defined in Section 66-402, Idaho Code, and Sections 500 through 503 of these rules, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/ID or receive services under one of Idaho's programs to assist individuals with intellectual disabilities or a related condition to avoid institutionalization in an ICF/ID, as indicated in Section 584.02 of these rules. To meet Title XIX and Title XXI entitlement for ICF/ID level of care and be eligible for services provided in an ICF/ID. The following must be met in Subsections 584.01 through 584.08 of these rules. (3-19-07)

**01. Diagnosis.** Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. (3-19-07)

**02. Active Treatment.** Persons living in an ICF/ID, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain his functional level. (3-19-07)

a. Active treatment does not include: parenting activities directed toward the acquisition of age-appropriate developmental milestones; services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program or services; interventions that address age-appropriate limitations; or general supervision of children whose age is such that such supervision is required by all children of the same age. (3-19-07)

b. The following criteria/components will be utilized when evaluating the need for active treatment: (3-19-07)

i. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the participant and the interventions needed; and (3-19-07)

ii. Plan of Care. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. (3-19-07)

**03. Must Require Certain Level of Care.** Persons living in the community must require the level of care provided in an ICF/ID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future. (3-19-07)

**04. Care for a Child.** The department may provide Medicaid to a child eighteen (18) years of age or younger, who would be eligible for Medicaid if they were in a medical institution and who are receiving, while living at home, medical care that would be provided in a medical institution, if the Department determines that the child requires the level of care provided in an ICF/ID. (3-19-07)

**05. Functional Limitations.** (3-19-07)

a. Persons Sixteen Years of Age or Older. Persons ~~(sixteen (16) years of age or older)~~ may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment ~~(Woodcock Johnson Scales of Independent Behavior, or SIB-R, or subsequent revisions)~~ using a Department-approved assessment tool would qualify; or ~~(3-19-07)~~( )

b. Persons Under Sixteen Years of Age. Persons ~~(under sixteen (16) years of age)~~ qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or ~~(3-19-07)~~( )

**06. Maladaptive Behavior.** (3-19-07)

a. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/ID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on ~~the Woodcock Johnson Scales of Independent Behavior (SIB-R) or subsequent revision~~ a Department-approved assessment tool is minus twenty-two (-22) or less; or ~~(3-19-07)~~( )

b. Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/ID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or (3-19-07)

**07. Combination Functional and Maladaptive Behaviors.** Persons may qualify for ICF/ID level of care if they display a combination of criteria as described in Subsections 584.05 and 584.06 of these rules at a level that is significant and it can be determined they are in need of the level of services provided in an ICF/ID, including active treatment services. Significance would be defined as: (3-19-07)

a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on ~~the Woodcock Johnson SIB-R~~ a Department-approved assessment tool up to minus seventeen (-17), minus twenty-two (-22) inclusive; or ~~(3-19-07)~~( )

b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on ~~the Woodcock Johnson SIB-R~~ a Department-approved assessment tool between minus seventeen (-17), and minus twenty-one (-21) inclusive; or ~~(3-19-07)~~( )

**08. Medical Condition.** Individuals may meet ICF/ID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/ID, including active treatment services. (3-19-07)

**09. Annual Redetermination for ICF/ID Level of Care for Community Services.** The RMS staff must redetermine the participant's continuing need for ICF/ID level of care for community services. Documentation will consist of the completion of a redetermination statement on the "Level of Care" form HW0083. Such documentation will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination. (3-19-07)

**a.** Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/ID eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. (3-19-07)

**b.** Developmentally Disabled Waiver. Individuals receiving developmentally disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. (3-19-07)

**(BREAK IN CONTINUITY OF SECTIONS)**

**682. CHILDREN'S WAIVER SERVICES: ELIGIBILITY.**

Waiver eligibility will be determined by the Department as described in Section 522 of these rules. Children's waiver participants must meet the following requirements: (7-1-11)

**01. Age of Participants.** The following waiver programs are available for children: (7-1-11)

**a.** Children's DD Waiver. Children's DD waiver participants must be birth through seventeen (17) years of age. (7-1-11)

**b.** Act Early Waiver. Act Early waiver participants must be three (3) through six (6) years of age. (7-1-11)

**02. Eligibility Determinations.** The Department must determine that: (7-1-11)

**a.** The participant would qualify for ICF/ID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 683 of these rules were not made available; and (7-1-11)

**b.** The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the family-centered planning team. Prior to any denial of services, it must be determined by the plan developer that services to correct the concerns of the team are not available. (7-1-11)

**c.** The average annual cost of waiver services and other medical services to participants would not exceed the average annual cost to Medicaid of ICF/ID care and other medical costs. (7-1-11)

**d.** Following the approval by the Department for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (7-1-11)

**03. Additional Act Early Waiver Requirements.** In addition to the requirements listed in Subsections 682.01 and 682.02 of this rule, a participant must have the following characteristics to qualify for Act Early waiver services: (7-1-11)

**a.** An autism spectrum diagnosis; or (7-1-11)

**b.** Self-injurious, aggressive, or severely maladaptive behavior as evidenced by a General Maladaptive Index score of minus twenty-two (-22) or below on ~~the Scales of Independent Behavior - Revised (SIB-R)~~ a Department-approved assessment tool or other behavioral assessment indicators identified by the Department

and a severe deficit, defined as having a composite full scale functional age equivalency of fifty percent (50%) or less of the participant's chronological age. ~~(7-1-11)~~( )

**04. Children's Waiver Eligible Participants.** A participant who is determined by the Department to be eligible for services under the children's waivers may elect not to use waiver services, but may choose admission to an ICF/ID. (7-1-11)

**05. Home and Community-Based Waiver Participant Limitations.** The number of Medicaid participants to receive waiver services under the children's waivers for participants with developmental disabilities will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after June 30th of each new waiver year. (7-1-11)