

Dear Senators VanOrden, Bjerke, Wintrow, and  
Representatives Vander Woude, Erickson, Rubel:

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

IDAPA 16.03.26 - Medicaid Plan Benefits-Proposed Rule (Docket No. 16-0326-2601).

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 10/30/2026. 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 11/27/2026.

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 334-4854, or send a written request to the address on the  
memorandum attached below.



**Terri Kondeff**  
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:** Legislative Drafting Attorney - Kyle Slominski  
**DATE:** October 13, 2026  
**SUBJECT:** Department of Health and Welfare

IDAPA 16.03.26 - Medicaid Plan Benefits-Proposed Rule (Docket No. 16-0326-2601)

#### **Summary and Stated Reasons for the Rule**

The Department of Health and Welfare submits notice of proposed rulemaking at IDAPA 16.03.26 - Medicaid Plan Benefits (Docket No. 16-0326-2601). The Department states that the rule changes were proposed to make adjustments for a more efficient operating of the State Medicaid program. The Department states that the changes align with Session Laws from the Idaho Legislature and are responsive to CMS and provider network feedback on various topics. The Department states that the changes do not create new services. The Department further states that some of the changes relieve the burden on providers. The Department further states that some of the changes simplify and clarify language or meaning where existing language creates unintentional ambiguity. The Department further states that some of the changes better position the Department to administer the State Medicaid program and exercise effective utilization management.

#### **Negotiated Rulemaking / Fiscal Impact**

The Department of Health and Welfare states that negotiated rulemaking was conducted and that notice was published in the July 1, 2026, Idaho Administrative Bulletin, Volume 26-7, pages 71-72. There is no fiscal impact anticipated with this rulemaking.

#### **Statutory Authority**

The proposed rule appears to be within the statutory authority granted to the Department of Health and Welfare pursuant to Sections 56-202(b), 56-265, and 56-276, Idaho Code.

cc: Department of Health and Welfare  
Jared Larsen

\*\*\* PLEASE NOTE \*\*\*

|                                                              |                                               |                                                  |                                             |                                                |
|--------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|---------------------------------------------|------------------------------------------------|
| Paul Headlee, Deputy Director<br>Legislative Services Office | Matt Drake, Manager<br>Research & Legislation | Keith Bybee, Manager<br>Budget & Policy Analysis | April Renfro, Manager<br>Legislative Audits | Norma Clark, Manager<br>Information Technology |
|--------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|---------------------------------------------|------------------------------------------------|

Statehouse, P.O. Box 83720  
Boise, Idaho 83720-0054

Tel: 208-334-2475  
legislature.idaho.gov

Per the Idaho Constitution, all administrative rules may be reviewed by the Legislature during the next legislative session. The Legislature has 3 options with this rulemaking docket: **1)** Approve the docket in its entirety; **2)** Reject the docket in its entirety; or **3)** Reject the docket in part.

## IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

### 16.03.26 – MEDICAID PLAN BENEFITS

#### DOCKET NO. 16-0326-2601

#### 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 Section(s) [56-202\(b\)](#), [56-265](#), and [56-276](#), Idaho Code.

**PUBLIC HEARING SCHEDULE:** Public hearings concerning this rulemaking will be held as follows:

| Friday, October 16, 2026<br>3:00 p.m. (MT)                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Wednesday, October 21, 2026<br>2:00 p.m. (MT)                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>In Person:</b><br/>450 W. State Street, 10th Floor, Boise ID 83720<br/>Conference Rm 10B</p> <p><b>Meeting link:</b><br/><a href="https://teams.microsoft.com/meet/268008390535088?p=Z1uN8PlvX7JQktHaEu">https://teams.microsoft.com/meet/268008390535088?p=Z1uN8PlvX7JQktHaEu</a><br/>Meeting ID: 268 008 390 535 088<br/>Passcode: qx3g6cn7</p> <p><b>Dial in by phone</b><br/>1 972-454-4077 United States, Dallas<br/>Boise 1-208-609-5034<br/>Phone conference ID: 894 169 67#</p> | <p><b>In Person:</b><br/>450 W. State Street, 10th Floor, Boise ID 83720<br/>Conference Rm 10B</p> <p><b>Meeting link:</b><br/><a href="https://teams.microsoft.com/meet/2280965511466?p=788GW5rm0K7d4Ets0n">https://teams.microsoft.com/meet/2280965511466?p=788GW5rm0K7d4Ets0n</a><br/>Meeting ID: 228 096 551 146 6<br/>Passcode: rA22Do75</p> <p><b>Dial in by phone:</b><br/>1 972-454-4077 United States, Dallas<br/>Boise 1-208-609-5034<br/>Phone conference ID: 168 238 115#</p> |

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

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

These rule changes are proposed to make adjustments for more efficient operation of the State Medicaid program. They align with session laws from the Idaho Legislature and are responsive to CMS and provider network feedback on various topics. The changes do not create new services. Some changes relieve burden on providers. Some changes simplify and/or clarify language or meaning, often where existing language creates unintentional ambiguity. Some changes better position the Department to administer the State Medicaid program and exercise effective utilization management.

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

Fees will not be increased as a result of this rulemaking.

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

There is not anticipated to be a negative fiscal impact exceeding \$10,000.

**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 July 1, 2026, Idaho Administrative Bulletin, [Vol. 26-7 pages 71-72](#).

**INCORPORATION BY REFERENCE:** Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

**ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS:** For assistance on technical questions concerning the proposed rule, contact Estela Cabrera at [DHWRules@dhw.idaho.gov](mailto:DHWRules@dhw.idaho.gov) or (208) 334-5500.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 28, 2026.

DATED this 7th day of October, 2026.

Jared Larsen  
Chief of Staff  
Idaho Department of Health & Welfare  
450 W. State Street, 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
(208) 334-5500 phone; (208) 334-6558 fax  
[DHWRules@dhw.idaho.gov](mailto:DHWRules@dhw.idaho.gov)

**THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0326-2601  
(Only Those Sections With Amendments Are Shown.)**

**16.03.26 – MEDICAID PLAN BENEFITS**

**000. LEGAL AUTHORITY.**

Sections ~~56-202(b), and 56-265, and 56-276,~~ Idaho Code.

(7-1-26)(    )

**(BREAK IN CONTINUITY OF SECTIONS)**

**003. BACKGROUND CHECK ~~REQUIREMENTS.~~**

**01. ~~Background Check Compliance.~~** Background checks are required for specific providers under these rules. Providers who are required to have a background check and their contractors must comply with IDAPA ~~16.05.06.~~ **Waiver for CSW.** A participant may choose to waive the background check requirement for a CSW under consumer-directed services. A waiver must be completed under these rules. (7-1-26)(    )

**02. ~~Variances.~~** (7-1-26)

**a. ~~The Department may allow variances to clearance requirements under certain circumstances. Applicable providers must still complete an application for a background check.~~** (7-1-26)

**b. ~~Applicants with prior convictions for disqualifying drug and alcohol related offenses may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services.~~**

(7-1-26)

**032. Subsequent Convictions, Charges, or Investigations.** Once clearances are received, any subsequent criminal, adult, or child protection convictions, charges, or investigations must be immediately reported by the agency to the Department once known. (7-1-26)

**043. ~~Providers Subject to Background Check Requirements.~~ Independent CHIS Providers.** Independent CHIS providers are subject to background check requirements pursuant to Chapter 27, Title 56, Idaho Code and IDAPA 16.05.06. (7-1-26)( )

- a. ~~Adult Day Health Agencies.~~** (7-1-26)
- b. ~~Behavior Consultation or Crisis Management Providers.~~** (7-1-26)
- c. ~~Chore Services Providers.~~** (7-1-26)
- d. ~~Community Support Workers.~~** (7-1-26)
- e. ~~Contracted Non-Emergency Medical Transportation (NEMT) Providers, with direct contact with participants except for Individual Contracted NEMT providers.~~** (7-1-26)
- f. ~~Independent CHIS Providers.~~** (7-1-26)
- g. ~~Non-Medical Transportation (NMT) Providers.~~** (7-1-26)
- h. ~~Personal Assistance Agencies (PAA), including PAAs Acting as Fiscal Intermediaries.~~** (7-1-26)
- i. ~~Provider types deemed by the Department to be at high risk for fraud, waste, or abuse.~~** (7-1-26)
- j. ~~Respite Care Providers.~~** (7-1-26)
- k. ~~Service Coordination Agencies.~~** (7-1-26)
- l. ~~Support Brokers.~~** (7-1-26)
- m. ~~Supported Employment Agencies.~~** (7-1-26)

**004. (RESERVED)**

**005. DEFINITIONS: A THROUGH H.**

**01. Activities of Daily Living (ADL).** Basic self-care activities that meet an individual's needs to sustain them in a daily living environment, and includes bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (7-1-26)

**02. Agency.** A business entity comprised of an administrator and their employees providing a Medicaid service. Individuals cannot be an agency. (7-1-26)

**03. Adult Day Health (ADH).** Defined in Section 67-5006(5), Idaho Code, as adult day care. (7-1-26)

**04. Amortization.** The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (7-1-26)

**05. Audit.** An examination of provider records documents and financial records outside of processes in IDAPA 16.05.07, to determine compliance with Medicaid requirements and regulations or quality assurance. (7-1-26)( )

**06. Budget Adjustment Factor (BAF).** Total budget for nursing facility (NF) payment established by the Idaho legislature effective on July 1 annually and compared to the annual expected Medicaid rates for the same rate year. BAF may be positive or negative and applies to all NF rates calculated under the established prospective rate system. BAF is not applied to the calculated customary charge for each NF nor applied to any retrospectively settled NF. (7-1-26)

**07. Case Mix Adjustment Factor.** Factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The facility-wide acuity is the average of the indexes corresponding to the cost reporting period. (7-1-26)

**08. Case Mix Index (CMI).** Numeric score assigned to each facility resident, based on their physical and mental condition projecting the relative resources needed to provide their care. (7-1-26)

**a. Facility-Wide CMI.** Average of the entire facility's CMIs identified at each picture date during the cost reporting period. If CMIs are unavailable for applicable quarters due to lack of data, CMIs from available quarters are used. (7-1-26)

**b. Medicaid CMI.** Average of the weighting factors assigned to each Medicaid resident in a facility on the picture date, based on their PDPM classification. Medicaid status is based upon information contained in the MDS databases. When Medicaid identifiers are found to be incorrect, the Department adjusts the Medicaid CMI and reestablishes the rate. (7-1-26)

**c. State-Wide Average CMI.** Simple average of all facilities "facility-wide" CMIs used to establish the rate limitation July 1st of each year. (7-1-26)

**09. Children's Habilitation Intervention Services (CHIS).** CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. (7-1-26)

**10. Children's Health Insurance Program (CHIP).** Medical assistance for children under Idaho's Title XXI State Plan. The term Medicaid for the purposes of this rule apply to CHIP. (7-1-26)

**11. Claim.** An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (7-1-26)

**12. CMS.** Centers for Medicare and Medicaid Services. (7-1-26)

**13. Community Support Worker (CSW).** An individual, agency, or vendor selected and paid by the participant to provide CSW services. (7-1-26)

**14. Conflict of Interest.** A situation in which an agency or person directly or indirectly influences, or appears to influence, the direction of a participant to other services for financial gain. ( )

**145. Consumer-Directed Community Supports (CDCS).** A flexible program option for participants eligible for the Children's Home and Community Based Services (HCBS) State Plan Option, and Adult Developmental Disabilities (DD) waiver. Supports include SDGS and FDGS program options. (7-1-26)

**156. Cost Report.** A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (7-1-26)

**167. Customary Charges.** The rates charged to Medicare participants and other paying patients as reflected in the facility's records. Charges are adjusted downward, when the provider does not hold most patients liable for payment on a charge basis or, when there are not reasonable collection efforts. Reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM. (7-1-26)

~~17. **Date of Discharge.** The day a participant is released from care that is not a day of care for nursing facilities. (7-1-26)~~

**18. Day Treatment Services.** Developmental services provided regularly during normal working hours on weekdays by, or on behalf of, an ICF/IID that do not include recreational, speech, physical, or occupational therapy, or other services paid for, or required to be provided by, a school or other entity. (7-1-26)

**19. Department.** The Idaho Department of Health and Welfare or its designee. (7-1-26)

**20. Director.** The Director of the Department or their designee. (7-1-26)

**21. Developmental Disability (DD).** As defined in Section 66-402(5), Idaho Code. (7-1-26)

~~22. **Dual Eligible.** Participants eligible for Medicaid under IDAPA 16.03.05, when their eligibility is not provided solely under the Woman Diagnosed with Breast or Cervical Cancer program, and who are enrolled in both Medicare Parts A and B. (7-1-26)~~

~~23.~~ **Durable Medical Equipment (DME).** Equipment and appliances that are not orthotics or prosthetics; are primarily and customarily used to serve a medical purpose; are generally not useful to an individual in the absence of a disability, illness, or injury; can withstand repeated use; can be reusable or removable; and are suitable for use in any setting in which normal life activities take place. (7-1-26)

~~24.~~ **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services.** Medically necessary services are health care, diagnostic services, treatment, and other measures necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether such services are covered under the State Plan. (7-1-26)

~~25.~~ **Educational Services.** Services provided online, in buildings or areas designated for use as a school or educational setting; provided during time periods in which educational instruction takes place in the school day; included in a participant's individual educational plan for school-age individuals. (7-1-26)( )

~~26.~~ **Evidence-Based Interventions.** Interventions that have been scientifically researched and reviewed in peer-reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model (EBM). (7-1-26)

~~26.~~ **Evidence-Informed Interventions.** Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual, who are not certified or credentialed in an EBM. (7-1-26)

~~27.~~ **Facility.** Facility refers to a hospital, nursing facility (NF), or intermediate care facility for individuals with intellectual disabilities (ICF/IID). (7-1-26)

~~28.~~ **Family-Directed Community Supports (FDCS).** A program option for children eligible for Children's HCBS State Plan Option. (7-1-26)

~~30.~~ **Financial Management Services (FMS).** Services provided by an FEA. (7-1-26)

~~31.~~ **Fiscal Employer Agent (FEA).** An agency that provides FMS selected by participants who have chosen the CDCS option. FEA is selected by the participant. (7-1-26)

~~31. **Gold Card.** A program for managed care providers eligible for exemption from prior authorization requirements pursuant to Section 56-276, Idaho Code. ( )~~

~~a. **Card Rescission.** The methodology for determining a provider's risk-weighted claim sampling score and the acceptable benchmark for rescission of a gold card can be found in the Idaho Medicaid Provider Handbook. ( )~~

32. **Goods.** Tangible products or merchandise that are authorized on the SSP. (7-1-26)

33. **Home and Community Based Services (HCBS).** Long-term services and supports ~~that assist delivered to eligible~~ participants ~~to remain in their~~ home ~~and or~~ community ~~settings that enable them to live as independently as possible.~~ HCBS can be authorized to address an assessed need when safe and effective, and the person-centered planning process is included. Services must be medically necessary or decrease the need for institutional care and other Medicaid services, promote community inclusion, or increase the participant's safety, and comply with federal requirements. (7-1-26)( )

34. **Human Services Field.** A diverse field that is focused on improving the quality of life for participants. Areas of academic study include, but are not limited to, sociology, special education, counseling, psychology, or other areas of academic study as referenced in the Medicaid Provider Handbook. (7-1-26)

35. **Idaho Behavioral Health Plan (IBHP).** A PIHP that provides behavioral health coverage for Medicaid participants. Behavioral health services include mental health and substance use disorder treatment and case management services. The provision of behavioral health services, as authorized through the IBHP contract, are provided to participants by a network of behavioral health providers. ( )

**006. DEFINITIONS: I THROUGH O.**

01. **Idaho Medicaid Provider Handbook.** A document that contains policy for the implementation and operations of the Medicaid program. (7-1-26)

02. **In-State Care.** Medical services not including long-term care provided within Idaho or in counties bordering Idaho. (7-1-26)

03. **Inspection of Care Team (IOCT).** Interdisciplinary team providing inspection of care in licensed ICFs/IID composed of: (7-1-26)

a. An RN; and (7-1-26)

b. A QIDP; and when required, a: (7-1-26)

i. Consultant physician; (7-1-26)

ii. Consultant social worker; or (7-1-26)

iii. When appropriate, other health and human services employees or consultants of the Department. (7-1-26)

04. **Instrumental Activities of Daily Living (IADL).** Activities performed to support ADL, including, but not limited, to, managing money, preparing meals, shopping, light housekeeping, communicating, or accessing the community. (7-1-26)( )

05. **Integration.** Promoting a lifestyle for HCBS participants like other community members, including those living in and accessing community resources to enhance the social image and personal competence of HCBS participants. (7-1-26)

06. **Interim Reimbursement Rate (IRR).** Rate paid for each Medicaid patient day intended to result in total Medicaid payments approximating the amount paid at audit settlement and intended to include any payments allowed over the percentile cap. (7-1-26)

07. **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).** An entity licensed as an ICF/IID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. (7-1-26)

**08. Level of Care.** The classification in which a participant is placed, based on severity of need for institutional care. (7-1-26)

**09. Level of Support.** Amount of services and supports necessary to allow a participant to live independently and safely in the community, as derived from a Department-approved assessment tool. (7-1-26)

**10. Licensed Bed Capacity.** Number of beds approved by the State's Licensure and Certification Agency for rendering patient care. (7-1-26)

**11. Lower of Cost or Charges.** Payment to providers (other than public providers furnishing services free of charge or at nominal charges to the public) that is the lesser of the reasonable cost of services or customary charges of like services. Public providers furnishing services free of charge or at a nominal charge are reimbursed fair compensation; considered reasonable cost. (7-1-26)

**12. Major Movable Equipment.** Major movable equipment as defined in Section 56-101(16), Idaho Code, that also has a unit cost of five thousand dollars (\$5,000) or more. (7-1-26)

**13. Medicaid-Related Ancillary Costs.** Services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs are determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, is considered Medicaid-related ancillaries. (7-1-26)

**14. Medical Assistance (Medicaid).** Payments for part or all of the cost of services, capitation payments, or managed care costs funded by Titles XIX or XXI of the federal Social Security Act (SSA). (7-1-26)

**15. Medical Necessity (Medically Necessary).** A service or item is medically necessary if: (7-1-26)

**a.** It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; (7-1-26)

**b.** There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly; (7-1-26)

**c.** It meets any applicable Department criteria. Services that do not meet criteria require a PA; (7-1-26)

**d.** Medical services must be of a quality that meets professionally recognized standards of health care and is substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (7-1-26)

**16. Medical, Social, and Developmental Assessment (MSDA) Summary.** Form used by the Department to gather a participant's medical, social, and developmental history and other summary information required for all DD HCBS program participants under a service plan used to assess and authorize services. (7-1-26)( )

**17. Medical Supplies.** Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (7-1-26)

**18. Minimum Data Set (MDS).** Set of screening, clinical, and functional status elements, including common definitions and coding categories, forming the foundation of a comprehensive assessment for all residents of long-term care facilities certified under Medicare or Medicaid. Updated versions of the MDS are evaluated and incorporated into rate setting as necessary. (7-1-26)

**19. Minor Movable Equipment.** Minor movable equipment as defined in Section 56-101(18), Idaho

Code, with a unit cost under five thousand dollars (\$5,000.) (7-1-26)

**20. Nominal Charges.** A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (7-1-26)

**21. Order.** Written instructions from a healthcare professional acting within the scope of their practice for a participant's treatment, medications, tests or procedures. Orders shall include: (7-1-26)

**a.** Participant's name; (7-1-26)

**b.** Description of item or service; (7-1-26)

**c.** Length of need, if applicable; (7-1-26)

**d.** Quantity, if applicable; (7-1-26)

**e.** Provider's name, National Provider Identification (NPI) and signature; and (7-1-26)

**f.** Date of signature. (7-1-26)

**22. Ordinary.** Costs incurred that are customary for normal operation of a business. (7-1-26)

**23. Orthotic.** Pertaining to or promoting the support of an impaired joint or limb. (7-1-26)

**007. DEFINITIONS: P THROUGH Z.**

**01. Participant.** A person eligible for and enrolled in Medicaid. (7-1-26)

**02. Patient Driven Payment Model (PDPM).** Process to group residents according to the clinical and functional status identified by responses to key elements of the MDS and used for rate setting and determining NF level of care. (7-1-26)

**03. Personal Assistance Agency (PAA).** An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for ~~personal assistants~~ direct care workers (DCW) working for them, and is the employer of record as well as the actual employer. (7-1-26)( )

**04. Plan Developer.** A Depending on service, a QIDP, a SB, an RN, or service coordinator identified by the participant responsible for developing a service plan and subsequent addenda covering all services and supports, based on a person-centered planning process. A plan developer may be paid, unpaid or the unpaid participant themselves. (7-1-26)( )

**05. Plan Monitor.** A person who oversees service delivery on a paid or non-paid basis. For DD services, the plan monitor is a service coordinator. (7-1-26)

**06. Plan of Care.** A written description of medical, remedial, habilitative, or rehabilitative services to provide to a participant, developed by or under the direction and written approval of a provider. Medications, services, and treatments shall be identified specifically by amount, type, and duration of service. (7-1-26)

**07. Primary Care Provider (PCP).** A healthcare professional acting within the scope of their practice, who is the first point of contact for routine medical concerns. (7-1-26)

**08. Prior Authorization (PA).** PA means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. (7-1-26)

**09. Property Rental Rate.** Rate paid per Medicaid patient day to free-standing nursing facilities in lieu of payment for property costs other than property taxes, insurance, and, for ICF/IID providers, costs of major

- movable equipment. (7-1-26)
10. **Prosthetic Device.** Replacement, corrective, or supportive devices to: (7-1-26)
- a. Artificially replace a missing portion of the body; (7-1-26)
- b. Prevent or correct physical deformities or malfunctions; or (7-1-26)
- c. Support a weak or deformed portion of the body. (7-1-26)
- d. Computerized communication devices are not included in this definition. (7-1-26)
11. **Provider.** Any individual acting under Section 020 including, but not limited to, certified registered nurse anesthetists, nurse practitioners, nurse midwives, clinical nurse specialists, pharmacists, physician assistants, and physicians. Alternatively, a partnership, association, corporation, or organization that furnishes medical goods or services in compliance with these rules. (7-1-26)( )
12. **Provider Status Review.** Written documentation identifying a participant's progress toward goals defined in their service plan. (7-1-26)
13. **Qualified Intellectual Disabilities Professional (QIDP).** As described in 42 CFR 483.430(a). (7-1-26)
14. **Quality Improvement Organization (QIO).** An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. (7-1-26)
15. **Recoupment.** As detailed in IDAPA 16.05.07. (7-1-26)
16. **Recreational Services.** Activities and goods that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties. (7-1-26)
17. **Readiness Review.** A review conducted by the Department to ensure that each FEA is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. (7-1-26)
18. **Referral.** A documented recommendation from a healthcare professional to see another Medicaid provider for a specific service. (7-1-26)
19. **Related Entity.** An organization associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (7-1-26)
20. **Restrictive Intervention.** Any intervention used to restrict rights or freedom of movement and includes chemical, mechanical, and physical restraints, or seclusion. (7-1-26)
21. **Retrospective Review.** A review of an item or service after it has been provided. The review determines medical necessity and conformity to Medicaid requirements. Claims that have already received payment may be subject to recoupment. (7-1-26)
22. ~~Rural Hospital-Based Behavioral Care Unit. A Rural Hospital-Based Provider that qualifies as a behavioral care unit.~~ **Self-Directed Community Supports (SDCS).** A program option for adults eligible for the Adult DD Waiver. (7-1-26)( )
23. **Service Coordination.** Case management activity to assist participants with gaining and coordinating access to necessary care and services appropriate to their needs. (7-1-26)
24. **Service Plan.** An initial or annual plan that identifies all services and supports based on a person-centered planning process and authorized by the Department. (7-1-26)

25. **Skilled Nursing Care.** Level of care for patients requiring twenty-four (24) hour skilled nursing services. (7-1-26)
26. **Supervision.** Supervision of a provider is procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (7-1-26)( )
27. **Support and Spending Plan (SSP).** A document that functions as a participant's plan of care when the participant is eligible for and has chosen a CDCS option. This document identifies the goods, services, and supports selected by a participant, including those available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each one. The participant uses this document to manage their individualized budget. (7-1-26)
28. **Support Broker (SB).** An individual who advocates on behalf of the participant and who is hired by the participant to provide SB services. (7-1-26)
29. **Supports.** Services provided for a participant, or a person who provides a support service that provide supervision and assistance to a participant or facilitate integration into the community. A support service for CDCS may be a paid service provided by a CSW, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. (7-1-26)( )
30. **Third Party.** Includes a person, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a participant. (7-1-26)
31. **Traditional Adult DD Waiver Services.** A program option for participants eligible for the Adult DD Waiver consisting of specific Medicaid Enhanced Plan Benefits. (7-1-26)
32. **Traditional Children's HCBS State Plan Option Services.** A program option for children eligible for the Children's HCBS State Plan Option consisting of specific Medicaid Enhanced Plan Benefits. (7-1-26)
33. **Utilization Control (UC).** Program of prepayment screening and annual review by the Department determining the appropriateness of and the need for continued medical entitlement of applicants or participants in a NF. (7-1-26)
34. **Utilization Control Team (UCT).** Team of Regional nurse reviewers that conducts on-site reviews of the care and services in NFs approved by the Department as Medicaid providers. (7-1-26)
35. **Vocational Services.** Services directly related to the preparation for paid or unpaid employment. Vocational services are provided with the expectation a participant will participate in a work services program or the general workforce within a year. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**022. PROVIDER AGREEMENTS.**

This section applies to all providers including Family Directed Community Supports (FDCS). (7-1-26)( )

01. **General.** All individuals or entities must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services. Agreements may contain any terms or conditions deemed appropriate by the Department. All provider agreements must be signed by an authorized representative who has the legal authority to bind the provider in the agreement. (7-1-26)
02. **Enforcement Actions and Terminations.** The Department may take any of the following actions for cause based on the conduct of the provider, or its employees or agents, or when the provider fails to comply with the provider agreement, or any applicable state or federal regulation: (7-1-26)

- a. Require corrective actions in [IDAPA 16.05.07](#); (7-1-26)
  - b. Require a corrective action plan to be submitted by the provider to address noncompliance with requirements; (7-1-26)
  - c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; (7-1-26)
  - d. ~~Revoke the provider's gold card status;~~ ( )
  - de. Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or (7-1-26)
  - ef. Terminate the provider's agreement. (7-1-26)
  - i. The Department may terminate provider agreements with or without cause by giving written notice to the provider as set forth in the agreement. (7-1-26)
  - ii. Terminations without cause may result from elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers or will result from the discretionary act of another regulatory body. If an agreement does not provide a notice period, the period is twenty-eight (28) days. (7-1-26)
  - iii. Terminations for cause may be appealed. (7-1-26)
- 03. Crossover Only Providers.** Providers of professional services may enroll as crossover only providers that bill for  ~~dual~~ eligible participants' ~~with~~ Medicare coinsurance and deductible. Crossover only providers act as non-billing ORPs for all other participants. (7-1-26)( )
- 04. Non-billing Ordering, Referring, and Prescribing (ORP).** Providers may enroll as non-billing ORPs, provided they follow the provider application process and sign a provider agreement. Non-billing ORPs are not eligible for reimbursement and are otherwise not Medicaid providers. (7-1-26)

**023. – 024. (RESERVED)**

**025. CONDITIONS FOR PAYMENT.**

- 01. Participant Eligibility.** The Department will reimburse providers for medically necessary services when a complete and properly submitted claim for payment has been received and each of the following conditions are met: (7-1-26)
- a. The participant received services no earlier than the third month before an application was made on the participant's behalf; (7-1-26)
  - b. The provider verified the participant's eligibility on the date of service and can provide proof of the eligibility verification; (7-1-26)
  - c. Services provided after the participant's date of death cannot be reimbursed; and (7-1-26)
  - d. Not more than twelve (12) months have elapsed since the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. When a participant is determined to be retroactively eligible, the Department will reimburse providers for services within the period of retroactive eligibility, if a claim is submitted within twelve (12) months of the participant's eligibility determination. (7-1-26)( )
- 02. Comply With All Applicable Regulations.** (7-1-26)

**03. Comply With the Idaho Medicaid Provider Handbook.** (7-1-26)

**04. Acceptance of State Payment.** Providers agree to accept as payment in full the amounts paid by the Department for covered services. Participants cannot be billed for covered services. Providers may only bill participants for non-covered services when the participant is notified in writing before the service is provided that it is non-covered and its cost. (7-1-26)

**05. Medical Care Provided Outside the State of Idaho.** Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (7-1-26)

**06. Ordering, Referring, and Prescribing Providers (ORP).** Any service ordered, prescribed, or referred by a provider who is not an enrolled Medicaid provider will not be reimbursed by the Department. (7-1-26)

**07. Referrals.** Medicaid services may require a referral. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a required referral are not covered and are subject to sanctions and recoupment. (7-1-26)

**08. Prior Authorization (PA).** The Department may require a PA for any service. Unless otherwise specified: (7-1-26)

**a.** Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid PA request. An exception may be allowed on a case-by-case basis, when events beyond the provider's control prevented the request's submission. (7-1-26)

**b.** The provider cannot bill the Medicaid participant for non-covered services solely because the authorization was not requested or obtained in a timely manner. (7-1-26)

**c.** An item or service will be deemed prior approved when the participant was not eligible for Medicaid when the service was provided, but was subsequently determined eligible under Medicaid eligibility rules, and the medical item or service provided is authorized by the Department. (7-1-26)

**d.** A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. (7-1-26)

**09. Follow-up Communication.** Medicaid services may require timely follow-up communication with the participant's PCP provider as listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication are not covered and subject to sanctions and recoupment. (7-1-26)

**026. THIRD-PARTY LIABILITY.**

**01. Determining Liability.** The Department will take reasonable measures to determine liability of third parties for services rendered to a participant. (7-1-26)

**02. Current Resource.** The Department will treat any third-party liability as a current resource when payment by the third-party has been made or will be made within a reasonable time. (7-1-26)

**03. Withholding Payment.** The Department will not withhold payment because of the liability of a third party when liability cannot be currently established or available to pay the participant's medical expense. (7-1-26)

**04. Seeking Third-Party Reimbursement.** The Department will seek reimbursement from a third party when liability existed, but was not treated as a current resource, with the exceptions provided under this rule. The Department will seek reimbursement from a participant in any situation in which the participant ~~has received~~ direct payment from any third-party for services received and does not forward ~~ed~~ the money to the Department ~~for~~

services received. (7-1-26)( )

**05. Billing Third Parties First.** Medicaid providers must bill all other sources of direct third-party payment, ~~with the following exceptions:~~ except when allowed by state or federal regulation. (7-1-26)( )

**a.** ~~When the resource is a court-ordered absent parent and there are no other viable resources available, the claims will be reimbursed, and the resources billed by the Department;~~ (7-1-26)

**b.** ~~Preventive pediatric care including early and periodic screening, diagnostic, and treatment services which includes:~~ (7-1-26)

**i.** ~~Well Child examinations for children under age twenty-one (21) years when provided according to guidance in the Idaho Medicaid Provider Handbook;~~ (7-1-26)

**ii.** ~~Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms;~~ (7-1-26)

**c.** ~~When PA has been approved under these rules, treatment services to control, correct, or ameliorate health problems found through diagnosis and screenings;~~ (7-1-26)

**d.** ~~If the claim is for preventative pediatric care under this rule, the Department will make payment for the service provided in its fee schedule and will seek reimbursement from the third party under 42 U.S.C. 1396a(a)(25)(E).~~ (7-1-26)

**06. Accident Determination.** When the participant's Medicaid card indicates private insurance or when the diagnosis indicates an accident for which private insurance is often carried, the claim will be suspended or denied until third party liability determination can occur. (7-1-26)

**07. Third-Party Payments.** The Department will pay the provider the lowest amount of the following: (7-1-26)

**a.** The provider's actual charge for the service; (7-1-26)

**b.** The maximum allowable charge for the service as established by the Department in its pricing file; (7-1-26)

**c.** The third-party allowed amount minus the third-party payment, or the patient liability as indicated by the third-party. (7-1-26)

**08. Subrogation of Third-Party Liability.** In all cases where the Department will be required to pay for a participant who is entitled to recover any medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of Medicaid benefits paid by the Department. (7-1-26)

**a.** If litigation or a settlement in such a claim is pursued by the Medicaid participant, the participant must notify the Department. (7-1-26)

**b.** If the participant recovers funds from a third party, the participant must repay the amount of benefits paid by the Department. (7-1-26)

**09. Subrogation of Legal Fees.** (7-1-26)

**a.** If a participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept, will be reduced by the total amount of attorney fees and court costs paid by the participant. (7-1-26)

b. If a settlement or judgment is received by the participant that does not specify which portion is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses in an amount equal to that paid by the Department. (7-1-26)

**027. – 029. (RESERVED)**

**030. GENERAL PAYMENT PROCEDURES.**

**01. Provided Services. (7-1-26)**

a. Providers must obtain the required information from the Electronic Verification System (EVS) by using the Medicaid number on the identification card from the EVS and transfer the required information onto the appropriate claim form. (7-1-26)

b. Upon providing the care and services to a participant, the provider or their agent must submit a properly completed claim to the Department including their usual and customary charge, which is the lowest charge by the provider to the general public for the same service including advertised specials. Each claim submitted by a provider constitutes an agreement to accept and abide by the Department's requirements. (7-1-26)

c. The Department is to process each claim received and make payment directly to the provider. (7-1-26)

d. The Department will not supply claim forms. Form examples needed to comply with the Department's unique billing requirements are included in the Idaho Medicaid Provider Handbook. (7-1-26)

**02. Provider Reimbursement. (7-1-26)**

a. Except where specified, the Department will pay the provider the lowest of: (7-1-26)( )

i. The provider's ~~actual~~ charge for service; ~~or~~ (7-1-26)( )

ii. The maximum allowable ~~charge for the service~~ as established by the Department on its pricing file ~~and or~~ Idaho Medicaid Provider Handbook; ~~or~~ (7-1-26)( )

iii. The Medicaid-allowed amount minus the ~~Medicare primary's~~ payment; ~~or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid.~~ (7-1-26)( )

iv. All-patient refined diagnosis related group (APR-DRG); or ( )

v. Member responsibility. ( )

b. Services and items without a Medicare price on file are priced for the maximum allowable charge at the Department's discretion per the following: (7-1-26)

i. Historical cost or regional reimbursement data. (7-1-26)

ii. Percent of charge. (7-1-26)

iii. A copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer or wholesaler. Reimbursement will be seventy-five percent (75%) of MSRP or quote. If the pricing documentation is an invoice for items, reimbursement will be at cost plus ten percent (10%), plus shipping. (7-1-26)

vi. An invoice with the usual and customary charges of the provider, and documentation in the form of operation reports, chart notes or medical records. (7-1-26)

v. HCBS are priced in accordance with approved service criteria. (7-1-26)

**03. Services Normally Billed Directly to the Patient.** If a provider bills services directly to patients, the provider must submit a claim form to the Department for reimbursement. (7-1-26)

**04. Other Noninstitutional Services.** The Department will reimburse for noninstitutional services unless otherwise specified. (7-1-26)

**05. Cost Reporting.** Providers subject to filing a Medicaid cost report must use the Department designated reporting forms, unless the Department approves an exception. Requests to use alternate forms must be sent to the Department in writing, with samples attached, ninety (90) days prior to the report due date. Requests are not a reason for late filing. (7-1-26)

**06. For Providers Subject to Retrospective Cost Settlement.** Following receipt of a finalized Medicare cost report and timely receipt of other requested information to fairly cost settle with a provider, the Department sends a certified letter with return receipt requested to the provider setting forth the underpayment or overpayment amounts made to the provider. The notice of results of a final retroactive adjustment ~~are~~ is sent even when a provider intends to appeal or has appealed the Medicare Intermediary's determination of cost settlement. When the determination shows that a provider owes Medicaid because total interim and other payments exceeded cost limits, the state takes the necessary action to recover overpayments, including suspending interim payments sixty (60) days after the provider receives the notice. Recovery or suspension actions continue even after the state receives a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments are made to the settlement amount. (7-1-26)(    )

**a.** The Department makes every effort to issue a notice of program reimbursement within twelve (12) months of receiving a cost report. (7-1-26)

**b.** A Medicaid completed cost settlement may be reopened by a provider or the state within a three (3) year period from the date of the notice of program reimbursement. The issues must have been raised, appealed, and resolved by reopening the Medicare Intermediary's cost report. Issues previously addressed and resolved by the state's appeal process are not cause to reopen a finalized cost settlement. (7-1-26)

**07. Procedures for Medicare Cross-Over Claims.** (7-1-26)

**a.** If a Medicaid participant is eligible for Medicare, the provider must first bill Medicare, or its designee, for the services before billing the Department. (7-1-26)(    )

**b.** If a provider accepts a Medicare assignment, the Department will forward payment to the provider automatically based upon the Medicare Summary Notice (MSN) that is received from the Medicare Part B Carrier. (7-1-26)

**c.** If a provider does not accept a Medicare assignment, an MSN must be submitted with a claim to the Department. (7-1-26)

**d.** For all other services, an MSN must be submitted to the Department with a claim. (7-1-26)

**e.** The Department will pay the provider for ~~the~~ services up to the Medicaid allowable amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together. (7-1-26)(    )

**08. Appeals Process.** Reimbursement for services originally denied by the Department will be made if such decision is reversed by the appeals process. (7-1-26)

**031. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS.** This section of rule applies only to providers that are retrospectively cost settled. (7-1-26)

**01. Interest Charges.** Medicaid charges interest on overpayments, and pays interest on underpayments, as follows: (7-1-26)

**a.** If full repayment from an indebted party is not received within sixty (60) days after the provider

received the Department reimbursement notice, interest accrues from the receipt date and is charged on any unpaid settlement balance for each thirty (30)-day period of delayed payment. Periods of less than thirty (30) days are treated as a full thirty (30)-day period, and the full interest charge is applied to any unpaid balance. Each payment is applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not allowable interest expenses. (7-1-26)

b. When the Department determines an overpayment exists, it may waive interest charges if the administrative costs to collect exceeds the charges. (7-1-26)( )

c. The interest rate on overpayments and underpayments is compounded monthly. (7-1-26)

d. Balance and interest are retroactively adjusted to equal the amounts that would have been due based on any changes that occurred due to results of a final determination in an administrative or judicial appeals process. Interest penalties only apply to unpaid amounts and are subordinated to final interest determinations made in a judicial review process. (7-1-26)

02. **Recovery Methods.** One (1) of the following will be used for recovery of overpayments: (7-1-26)

a. Upon receiving a notice of program reimbursement, a provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. (7-1-26)

b. The provider may: (7-1-26)

i. Request in writing to make overpayment recovery over a period of twelve (12) months or less; and (7-1-26)

ii. Submit documentation demonstrating that their financial integrity would be irreparably compromised if repayments occurred over a shorter time period. (7-1-26)

c. If a provider does not respond to the program reimbursement notice within thirty (30) days of receipt, the Department initiates recovery of the entire unpaid balance in addition to accrued interest. (7-1-26)

032. – 034. (RESERVED)

035. **RECORDS.**

Providers must maintain records in sufficient detail to allow the Department to audit for compliance, medical necessity, quality assurance, and determination of payment methodology. The Department, and the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review and copy pertinent records of providers and related entities receiving Medicaid reimbursement. These reviews may be conducted for audit purposes outside of processes in IDAPA 16.05.07. (7-1-26)( )

01. **Provider Refusal.** Refusal of a provider to permit the Department to review records pertinent to Medicaid will constitute grounds for: (7-1-26)

a. Withholding payments until access to the requested information is granted; (7-1-26)

b. Recoupment of payments; or (7-1-26)( )

c. Suspending the provider; (7-1-26)( )

d. Revoke the provider's gold card status; ( )

e. Exclusion from the Medicaid program; and/or ( )

f. Termination from the Medicaid program. ( )

02. **Undocumented Services.** Undocumented services are subject to recoupment. (7-1-26)

**03. Availability of Records.** Records must be available for audit, with or without prior notice, during any working day and regular business hours at the provider's principal place of business. (7-1-26)

**04. Retention of Records.** Providers will retain records required under this rule for a period of five (5) years from the date of final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to pay for services. (7-1-26)

**036. – 039. (RESERVED)**

**GENERAL REIMBURSEMENT PROVISIONS FOR INSTITUTIONAL PROVIDERS**  
**(Sections 040-049)**

**040. DOCUMENTATION FOR AUDITS.**

**01. Expenditure Documentation.** Must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting an expenditure. (7-1-26)

**02. Cost Allocation Process.** Include depreciation or amortization of assets and indirect expenses allocated to activities or functions based on the original identity of the costs. Documentation to support basis for allocation must be available for verification. The assets referred to in this Section of rule are economic resources of the provider recognized and measured in conformity with GAAP. (7-1-26)

**03. Revenue Documentation.** Must include the amount, date, purpose, and source of revenue. (7-1-26)

**04. Additional Documentation.** (7-1-26)

**a.** Providers are given an opportunity to provide documentation before an ~~an interim~~ final audit report is issued. (7-1-26)( )

**b.** Providers are not allowed to submit additional documentation in support of cost items after issuance of the ~~interim~~ final audit report. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**050. NF AND ICF/IID REIMBURSEMENT.**

**01. Reasonable Cost Principles.** To be allowable, costs must be reasonable, ordinary, necessary, and related to patient care. Providers are expected to incur costs in such a manner that economical and efficient delivery of quality health care to participants results. (7-1-26)

**02. Application of Reasonable Cost Principles.** Reasonable costs of any services are determined under this rule and the PRM, as modified by exceptions contained herein, and used to identify cost items included on Idaho's Uniform Cost Report. (7-1-26)

**a.** Reasonable costs account for both direct and indirect costs of provider services, including normal standby costs. (7-1-26)

**b.** Costs may vary from one (1) facility to another due to a variety of factors. Medicaid intends to reimburse providers for the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed under provisions of Title 56, Idaho Code, or unallowable by application of promulgated regulation. (7-1-26)

**c.** The expectation of reasonable actual operating costs is that providers seek to minimize costs and

that actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. (7-1-26)

d. The Department does not pay for costs determined to exceed a level that buyers incur in the absence of clear evidence that higher costs were unavoidable. (7-1-26)

e. Form and substance of transactions prevails over the form. Financial transactions are disallowed to the extent that the substance of a transaction fails to meet reasonable cost principles or comply with rules and policy. (7-1-26)

**03. Home Office Cost Principles.** Reasonable cost principles extend to home office costs allocated to individual providers. In addition, the home office, through a provider, provides documentation on the basis used to allocate costs among the various entities it administers or directs. (7-1-26)

**04. Application of Related Party Transactions.** (7-1-26)

~~a. Charges to a provider from related organizations may not exceed the billing to a related organization for these services. (7-1-26)~~

~~ba.~~ All home office costs unrelated to patient care are not allowable. (7-1-26)

**05. Compensation to Relatives.** Payment for relatives of owners or administrators is allowed only for actual services performed, when necessary, adequately documented, and reasonable. (7-1-26)

~~a.~~ Compensation billed to the Department must be included in compensation reported for tax purposes and actually paid. (7-1-26)( )

~~i. When services are performed without pay, no cost may be reported. (7-1-26)~~

~~ii. Time records documenting actual hours worked are required for compensation to allow for reimbursement. (7-1-26)~~

~~iii. Compensation for undocumented work hours is not reimbursable. (7-1-26)~~

~~b. Related persons are defined as these relationships with a provider: (7-1-26)~~

~~i. Spouse; (7-1-26)~~

~~ii. Child or a descendant of a child; (7-1-26)~~

~~iii. Siblings, stepsiblings, or descendant thereof; (7-1-26)~~

~~iv. Parent, stepparent, siblings thereof, and their ancestors; (7-1-26)~~

~~v. Related by marriage; (7-1-26)~~

~~vi. Any other person without an arm's length relationship. (7-1-26)~~

**06. Idaho Owner-Administrative Compensation.** Allowable compensation to owners and related persons providing any administrative services is based on bed count and limited to a set amount adjusted annually based upon changes in average hourly earnings in nursing and personal care facilities as published by a nationally recognized forecasting firm. (7-1-26)

a. Allowable compensation for providing administrative services is determined by: (7-1-26)

i. All licensed beds in every facility administrative services are provided. (7-1-26)

- ii. More than fifty (50) beds being restricted to an upper limit for compensation based on bed count. (7-1-26)
- iii. Less than fifty-one (51) beds being reimbursed at an allowable hourly rate. Non-administrative services are allowable at the reasonable market rate. Hours for each service type is documented. In no event will the total compensation for administrative and non-administrative duties exceed the limit applicable for the same amount for providing administrative services to facilities with fifty-one (51) or more beds. (7-1-26)

~~b. Compensation for persons related to an owner is evaluated in the same manner as for an owner.~~ (7-1-26)

~~eb.~~ When ~~an owner provides~~ services are provided to more than one facility, compensation is distributed on the same basis as costs allocated for non-owners. (7-1-26)( )

~~dc.~~ For more than one (1) ~~owner or related~~ party to receive compensation, services must be actually performed, documented, and necessary. Total compensation must be reasonable, and no greater than an amount for which the same services could be obtained on the open market. Standard full-time compensation is measured as two thousand eighty (2,080) hours. Compensation ~~of an owner or relative of an owner~~ will not exceed ~~the compensation determined from~~ the Administrative Compensation Schedule, and, when paid on an hourly basis, will not exceed ~~compensation determined~~ by the Administrative Compensation Schedule divided by two thousand eighty (2,080.) (7-1-26)( )

**07. Filing Dates.** (7-1-26)

a. Deadlines for annual cost reports are the last day of the third month following a fiscal year end or the deadline imposed by Medicare for providers required to file Medicare cost reports. (7-1-26)

b. Waivers to delay filing by thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for waivers and reasons must be submitted prior to the deadline. A written decision is rendered within ten (10) days. (7-1-26)

**08. Failure to File.** Late reports result in reductions to the interim rate. Failure to file required cost reports, including required supplemental information, unless a waiver is granted, results in a reduction of ten percent (10%) of the provider's rate(s) the first day of the month following a deadline date. Continued failure to comply results in complete payment suspension on the first day of the following month. When suspension or reduction occurs and a provider filed the required cost reports, amounts accruing to the provider during a suspension or reduction period are restored. Loss of license or certification results in immediate termination of reimbursement, full scope audit, and settlement for the cost period. (7-1-26)

**09. Accounting System.** Providers must file reports using the accrual basis and conform with GAAP or within provisions of the specified guidelines. Recorded transactions must be capable of verification by Departmental audit. (7-1-26)

**10. Audits.** (7-1-26)

a. All financial reports are subject to audit to: (7-1-26)

i. Determine that transactions recorded in the books of record are substantially accurate and reliable as a basis to determine reasonable costs. (7-1-26)

ii. Determine that facility internal controls are sufficiently reliable to disclose the results of a provider's operations. (7-1-26)

iii. Determine that Medicaid participants received the required care based on economy and efficiency. (7-1-26)

iv. Determine that GAAP is applied on a consistent basis in conformance with applicable federal and

- state regulations. (7-1-26)
- v. Ensure policies and practices sufficiently meet fiduciary responsibilities for patients, funds, and property. (7-1-26)
  - vi. Effect final settlement when required. (7-1-26)
  - b. Normally, all annual statements are audited within the following year. (7-1-26)
  - c. Other statements and some annual audit recommendations are subject to limited scope audits evaluating provider compliance. (7-1-26)
  - d. Additional audits are required for: (7-1-26)
    - i. Significant changes of ownership. (7-1-26)
    - ii. Changes in management. (7-1-26)
    - iii. When an overpayment of twenty-five percent (25%) or more resulted in a completed cost period. (7-1-26)
  - e. Annual field audits are by appointment. Auditors identify themselves with a letter of authorization or Department I.D. cards. (7-1-26)
- 11. Audit Standards and Requirements.** (7-1-26)
- a. Before making any program payments to a prospective provider, the intermediary reviews a provider's accounting system and its capability of generating accurate statistical cost data. When a provider's record keeping capability fails to meet program requirements, the intermediary offers limited consultative services or suggests revisions of a provider's system to enable compliance. (7-1-26)
  - b. Examination of records and documents includes: (7-1-26)
    - i. Corporate charters or other ownership documents including those for parent or related companies and attachments describing property. (7-1-26)
    - ii. Minutes and memos of governing bodies, including committees and its agents. (7-1-26)
    - iii. All contracts. (7-1-26)
    - iv. Tax returns and records, including workpapers and other supporting documentation. (7-1-26)
    - v. All insurance contracts and policies including riders and attachments. (7-1-26)
    - vi. Leases. (7-1-26)
    - vii. Fixed asset records ~~(see Capitalization of Assets).~~ (7-1-26) ( )
    - viii. Schedules of patient charges. (7-1-26)
    - ix. Notes, bonds, and other evidence of liabilities. (7-1-26)
    - x. Capital expenditure records. (7-1-26)
    - xi. Bank statements, canceled checks, deposit slips, and bank reconciliations. (7-1-26)
    - xii. Evidence of litigations involving a facility or its owners. (7-1-26)

- xiii. All invoices, statements, and claims. (7-1-26)
- xiv. Financial audit work-papers prepared by any accounting firm a provider engages with are considered the provider's property and must be available to the intermediary upon request, under PRM, Subparagraph 2404.4(Q). (7-1-26)( )
- xv. Ledgers, journals, all working papers, subsidiary ledgers, records, and documents relating to financial operation. (7-1-26)
- xvi. All patient records, including trust funds and property. (7-1-26)
- xvii. Time studies and other cost determining information. (7-1-26)
- xviii. All other sources of information needed to form an audit opinion. (7-1-26)
- c. Adequate cost information developed by a provider must be current, accurate, and sufficient detail to support payments made for services rendered. This includes all ledgers, books, records, and original cost evidence including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, time cards, payrolls, bases for apportioning costs, and other documentation pertaining to determination of reasonable cost, capable of being audited under PRM, Section 2304. (7-1-26)( )
- d. Adequate expense documentation includes invoices or statements with invoices attached supporting the statement and must include: (7-1-26)
  - i. Service or sale date; (7-1-26)
  - ii. Terms and discounts; (7-1-26)
  - iii. Quantity; (7-1-26)
  - iv. Price; (7-1-26)
  - v. Vendor name and address; (7-1-26)
  - vi. Delivery address if applicable; (7-1-26)
  - vii. Contract or agreement references; and (7-1-26)
  - viii. Description including quantities, sizes, specifications, and brand names of services performed. (7-1-26)
- e. Minor movable equipment is not capitalized. The cost of fixed assets and major movable equipment is capitalized and depreciated over the estimated useful life of an asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. (7-1-26)
- f. Completed depreciation records must include the following for each asset: (7-1-26)
  - i. Description of the asset including serial number, make, model, accessories, and location. (7-1-26)
  - ii. Cost basis supported by invoices for purchase, installation, etc. (7-1-26)
  - iii. Estimated useful life. (7-1-26)
  - iv. Depreciation method (straight line, double declining balance, etc.). (7-1-26)
  - v. Salvage value. (7-1-26)

- vi. Method of recording depreciation consistent with GAAP. (7-1-26)
- vii. Additional information, such as additional first year depreciation, even when not an allowable expense. (7-1-26)
- viii. Reported depreciation expense for the year and accumulated depreciation tied to the asset ledger. (7-1-26)
- g.** Depreciation methods are always acceptable. Methods of accelerated depreciation are only acceptable upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. (7-1-26)
- h.** An asset's depreciable life may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, Guidelines. Deviation from these guidelines is allowable only upon Department authorization. (7-1-26)
- i.** Lease purchase agreements are generally recognized by ~~any~~ the following characteristics: (7-1-26) ( )
  - i. Lessee assumes normal ownership costs, such as taxes, maintenance, etc.; (7-1-26)
  - ii. Intent to create security interest; (7-1-26)
  - iii. Lessee acquires title by exercising a purchase option that requires little or no additional payment or, additional payments substantially less than the fair market value at purchase date; (7-1-26)
  - iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; ~~and or~~ (7-1-26) ( )
  - v. Initial loan term significantly less than the useful life and lessee has the option to renew at a rental price substantially less than fair rental value. (7-1-26)
- j.** Assets acquired under such agreements are viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes, and maintenance are allowable. Rental or lease payments are not reimbursable. (7-1-26)
- k.** Complete personnel records including: (7-1-26)
  - i. Employment applications. (7-1-26)
  - ii. W-4 Forms. (7-1-26)
  - iii. Authorizations for any deductions such as insurance, credit union, etc. (7-1-26)
  - iv. Routine evaluations. (7-1-26)
  - v. Pay raise authorizations. (7-1-26)
  - vi. Statements of understanding of policies, procedures, etc. (7-1-26)
  - vii. Fidelity bond applications (when applicable). (7-1-26)
- l.** A system of internal control intended to provide a method of handling all routine and nonroutine tasks related to: (7-1-26)
  - i. Safeguarding assets and resources against waste, fraud, and inefficiency. (7-1-26)

- ii. Promoting accuracy and reliability in financial records. (7-1-26)
- iii. Encouraging and measuring compliance with company policy and legal requirements. (7-1-26)
- iv. Determining the degree of efficiency related to various aspects of operations. (7-1-26)
- m.** An adequate system of internal control over cash disbursements including: (7-1-26)
  - i. Payment on invoices only, or statements supported by invoices. (7-1-26)
  - ii. Authorizations for purchase; a purchase order. (7-1-26)
  - iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. (7-1-26)
  - iv. Verification of freight charges, discounts, credit memos, allowances, and returns. (7-1-26)
  - v. Check of invoice accuracy. (7-1-26)
  - vi. Invoice approval policy. (7-1-26)
  - vii. Method of invoice cancellation to prevent duplicating payment. (7-1-26)
  - viii. Adequate separation of duties between ordering, recording, and paying. (7-1-26)
  - ix. System separation of duties between ordering, recording, and paying. (7-1-26)
  - x. Signature policy. (7-1-26)
  - xi. Pre-numbered checks. (7-1-26)
  - xii. Statement of policy regarding cash or check expenditures. (7-1-26)
  - xiii. Adequate internal control over recording transactions in the books of record. (7-1-26)
  - xiv. An imprest system for petty cash. (7-1-26)
- n.** Sound accounting practices including: (7-1-26)
  - i. Documentation of accounting policies and procedures, including capitalization, depreciation, and expenditure classification criteria. (7-1-26)
  - ii. Chart of accounts. (7-1-26)
  - iii. Budget or operating plans. (7-1-26)
- 12. Patient Funds.** The safekeeping of Medicaid patient funds is the responsibility of the provider. Administration of these funds requires scrupulous care when recording all patient transactions. (7-1-26)
  - a.** Funds provided for a patient's personal needs are used at the patient's discretion. Providers agree to manage these funds and render an accounting of funds but may not use them in any way. (7-1-26)
  - b.** Providers are subject to legal and financial liabilities for committing any of the following acts and any other acts contrary to federal regulations: (7-1-26)
    - i. Management fees are not charged to manage patient trust funds and constitute double payment as normally performed by a facility employee whose salary is included in reasonable cost reimbursement. (7-1-26)

- ii. Nothing is to be deducted from these funds, unless deductions are authorized by the patient or their agent in writing. (7-1-26)
- iii. Interest accruing to patient funds on deposit is the patient's property and part of their personal funds. Interest from these funds is not available to the provider for any use, including patient benefits. (7-1-26)
- c. Fund Management. Proper management includes the following at a minimum: (7-1-26)
  - i. Savings accounts, maintained separately from facility funds. (7-1-26)
  - ii. An accurate system of supporting receipts and disbursements to patients. (7-1-26)
  - iii. Written authorization for all deductions. (7-1-26)
  - iv. Signature verification. (7-1-26)
  - v. Deposit of all receipts on the same day received. (7-1-26)
  - vi. Minimal funds kept in a facility. (7-1-26)
  - vii. All funds must always be locked. (7-1-26)
  - viii. Policy statement regarding patient's funds and property. (7-1-26)
  - ix. Periodic review of all policies with staff in training sessions and with all new employees upon employment. (7-1-26)
  - x. System of periodic review and correction of policies and financial records for patient property and funds. (7-1-26)

**13. Legal Consultant Fees and Litigation Costs.** When these costs are incurred by a provider, they are handled as follows: (7-1-26)

**a.** Legal consultant fees unrelated to preparation for or appealing of a Department audit, or costs incurred by a provider in an action unrelated to litigation with the Department are allowed as part of total per diem costs the Medicaid Program reimburses according to the percentage of Medicaid patient days. (7-1-26)

**b.** Costs of the provider's legal counsel when appealing findings of a Department audit are reimbursed by Medicaid only to the extent a provider prevails on the issues involved. Determination of the extent a provider prevails is based on the ratio of the total dollars at issue for an audit period under appeal to the total dollars ultimately awarded to a provider for that audit period. (7-1-26)

**c.** All other litigation costs incurred by a provider for actions against the Department are not directly or indirectly reimbursable by Medicaid, unless court ordered. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**054. SPECIALIZED REIMBURSEMENT: ELECTRONIC VISIT VERIFICATION (EVV).**

- 01. Services Requiring EVV.** (7-1-26)
  - a.** Home Health. (7-1-26)
  - b.** State Plan PCS provided by a PAA. (7-1-26)( )

- c. Attendant Care, Homemaker and Respite under the A&D Waiver provided by a PAA. (7-1-26)( )
02. **EVV Requirements.** Providers must: (7-1-26)
- a. Select and maintain an EVV system and certified as compliant with the Department's MMIS aggregator; (7-1-26)
- b. Retain documented participant consent for the provider's EVV methods; (7-1-26)
- c. Develop and maintain policies and procedures for use of EVV technology, including strategies for safeguarding participant data and privacy; and (7-1-26)
- d. Submit EVV data capturing six (6) system-validated data elements for services rendered: (7-1-26)
- i. Service date; (7-1-26)
- ii. Service start and end times; (7-1-26)
- iii. Direct service provider; (7-1-26)
- iv. Recipient of service; (7-1-26)
- v. Billable service; and (7-1-26)
- vi. Service delivery location. (7-1-26)
- e. Submit EVV data to the State's aggregator prior to billing claims. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**060. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAID.**

01. **Service Categories Not Covered.** The following service categories are not covered for payment by Medicaid except as otherwise specified: (7-1-26)
- a. Acupuncture services; (7-1-26)
- b. Naturopathic services; (7-1-26)
- c. Bio-feedback therapy, unless used for urinary incontinence; (7-1-26)( )
- ~~d. Group hydrotherapy;~~ (7-1-26)
- ~~e.~~ Fertility-related services, including testing; (7-1-26)
- ~~f.~~ Vocational services except for supported employment services; (7-1-26)
- ~~g.~~ Educational services; (7-1-26)
- ~~h.~~ Recreational services; (7-1-26)
- ~~i.~~ Duplicative services; (7-1-26)
- ~~j.~~ Housing except when approved for a medical institution; and (7-1-26)( )

~~ki.~~ Food, except when medically necessary ~~or the home-delivered-meals benefit.~~ (7-1-26)(    )

**02. Types of Treatments and Procedures Not Covered.** The costs of provider and hospital services for the following types of treatments and procedures are not covered for payment by Medicaid: (7-1-26)

**a.** Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; (7-1-26)

**b.** Services for convenience, comfort, or cosmetic reasons except when allowed elsewhere in rule. Hospice services, and reconstructive surgery that has prior approval by the Department are covered benefits; (7-1-26)

~~c.~~ Lactrile therapy; (7-1-26)

~~dc.~~ New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program or major commercial carriers; (7-1-26)

~~ed.~~ Drugs supplied to patients for self-administration other than those allowed under these rules; (7-1-26)

~~fe.~~ The treatment of complications, consequences, or repair of any medical procedure where the original procedure was not covered by Medicaid, unless the resultant condition is life-threatening as determined by the Department; (7-1-26)

~~gf.~~ Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; (7-1-26)

~~hg.~~ Surgical procedures on the cornea for myopia; or (7-1-26)

~~ih.~~ Services as detailed in Section 56-273, Idaho Code. (7-1-26)

**03. Experimental Treatments or Procedures.** Experimental treatments and procedures, and the costs for all follow-up medical treatment directly associated with such a procedure are not covered. Treatments and procedures are deemed experimental under the following circumstances: (7-1-26)

**a.** The treatment or procedure is in Phase I clinical trials; (7-1-26)

**b.** There is inadequate available clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or (7-1-26)

**c.** Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**074. HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.**

The upper payment limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare principles of cost reimbursement. (7-1-26)

**01. Payment Procedures.** The following procedures are applicable to in-patient hospitals: (7-1-26)

**a.** The participant's admission and length of stay may be subject concurrent review, continued stay

review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. Failure to obtain a timely QIO review as required by these rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. (7-1-26)

**b.** In reimbursing hospitals, the Department will pay the lesser of customary hospital charges or Medicaid reimbursement for in-patient hospital care as set forth in this rule, unless an exception applies. The upper limits for payment must not exceed the payment that would be determined as reasonable cost using Medicare standards and principles. (7-1-26)

**02. Administratively Necessary Days (AND) Reimbursement Rate.** Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho NFs for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. (7-1-26)

**a.** The AND reimbursement rate will be calculated by the Department of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (7-1-26)

**b.** Hospitals with an attached NF will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (7-1-26)

**c.** The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. (7-1-26)

**03. Hospital Swing-Bed Reimbursement.** The Department will pay for NF care in certain rural hospitals for participants in licensed hospital swing-beds who require NF level of care. (7-1-26)

**a.** Routine services include all medical care, supplies, and services that are included in the calculation of NF property and non-property costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except prescription drugs will be reimbursed under these rules. (7-1-26)

**b.** The Department will reimburse hospitals for participants under the following conditions: (7-1-26)

**i.** The participant is determined to be entitled to such services in accordance with [IDAPA 16.03.05](#); and (7-1-26)

**ii.** The participant is authorized for payment of long-term care. (7-1-26)

**c.** The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: (7-1-26)

**i.** Payment rates for routine NF services will be at the weighted average Medicaid rate per patient day paid to hospital-based NF for routine services furnished during the previous calendar year. (7-1-26)

**ii.** The rate will be calculated by the Department of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. (7-1-26)

**iii.** The weighted average rate for NF swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. (7-1-26)

**iv.** Routine services include all medical care, supplies, and services that are included in the calculation of NF property and nonproperty costs. (7-1-26)

**v.** Reimbursement of ancillary services not included in the NF rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with

Medicare reasonable cost principles, except that reimbursement for prescription drugs under these rules. (7-1-26)

vi. The Department may authorize additional critical access hospital swing-bed days for participants residing in a community without a nursing facility within thirty-five (35) miles. ( )

**04. Adjustment for Disproportionate Share Hospitals (DSH).** All Idaho hospitals serving a disproportionate share of low-income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. The Department will send each hospital a DSH survey on or before January 31 of each calendar year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. (7-1-26)

**a.** Mandatory Eligibility for DSH status will be provided for hospitals that: (7-1-26)

i. Meet or exceed the disproportionate share threshold under these rules. (7-1-26)

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. (7-1-26)

(1) This subsection does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or (7-1-26)

(2) Does not offer nonemergency inpatient obstetric services. (7-1-26)

iii. The MUR will not be less than one percent (1%). (7-1-26)

iv. If an Idaho hospital exceeds both disproportionate share thresholds and other mandatory eligibility is met, the payment adjustment will be the greater amount calculated using the methods of this rule except when less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals. (7-1-26)

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-26)

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates: (7-1-26)

(1) Equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-26)

(2) Exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-26)

vii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding: (7-1-26)

(1) Twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-26)

(2) Thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. (7-1-26)

**b.** All hospitals in Idaho that have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days and meet the requirements unrelated to patient day utilization specified in this subsection will be designated a DSH Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of:

(7-1-26)

- i. Five dollars (\$5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or (7-1-26)
- ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. (7-1-26)
- c. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. (7-1-26)
- d. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. (7-1-26)
  - i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third-party payment. (7-1-26)
  - ii. Claims of uninsured costs that increase the maximum amount that a hospital may receive as a DSH payment must be documented. (7-1-26)
- e. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. (7-1-26)
- f. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. (7-1-26)
  - i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. (7-1-26)
  - ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." (7-1-26)
  - iii. If based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: (7-1-26)
    - (1) Recover the overpayment from the provider; and (7-1-26)
    - (2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. (7-1-26)
  - iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the SSA. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. (7-1-26)
- 05. Out-of-State Hospitals.** Hospitals will have a cost settlement computed with the state of Idaho if the following conditions are met: (7-1-26)
  - a. Total inpatient and outpatient covered charges are more than fifty thousand dollars (\$50,000) in the fiscal year; or (7-1-26)
  - b. When less than fifty thousand dollars (\$50,000) of covered charges are billed to the state by the

provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. (7-1-26)

**06. Audit Function.** Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Medicare and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. (7-1-26)

**07. Adequacy of Cost Information.** Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. (7-1-26)

**08. Interim Cost Settlements.** The Department may initiate, or a hospital may request an interim cost settlement based on the Medicare cost report as submitted, for hospitals subject to cost settlement. (7-1-26)

**a.** Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. (7-1-26)

**b.** The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. (7-1-26)

**09. Non-Appealable Items.** The formula for the determination of the hospital inflation index, the principles of reimbursement that define allowable cost, non-Medicaid program issues, interim rates that follow state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits are not acceptable as appealable items. (7-1-26)

**10. Interim Reimbursement Rates for Providers Subject to Cost Settlement.** The interim reimbursement rates must be reasonable and adequate to meet the necessary costs that are incurred by economically and efficiently operated providers that provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. (7-1-26)

**a.** Interim rates will be adjusted at least annually based on the best information available to the Department. (7-1-26)

**b.** Interim rates will not be adjusted retrospectively upon request for rate review by the provider. (7-1-26)

**c.** The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars (\$100,000), the interim rate will be adjusted to account for half (½) of the difference. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**102. CASE MANAGEMENT: COVERAGE AND LIMITATIONS.**

**01. Home Visiting Coverage.** (7-1-26)

**a.** Assessment for medical, educational, social, or other service needs; (7-1-26)

- b. Development and revision of a plan to address goals; (7-1-26)
- c. Referral and related activities for necessary services; and (7-1-26)
- d. Monitoring of progress. (7-1-26)
- ~~e. Services do not include case management integral to another covered service or that constitutes direct delivery of referred services. (7-1-26)~~

**02. Community Re-entry Services.** Medicaid will reimburse for targeted case management services for eligible incarcerated participants thirty (30) days prior to, and thirty (30) days after, their release into the community. Services include transitioning back into the community by providing access to behavioral, educational, social, and other services. (7-1-26)

**03. Duplication.** Services do not include case management integral to another covered service or that constitutes direct delivery of referred services. (7-1-26)

**103. (RESERVED)**

~~**104. CASE MANAGEMENT: PROVIDER QUALIFICATIONS AND DUTIES.**  
Home visiting services are provided by the Public Health Districts or their designee. Eligible providers are certified in an evidence-based model including either Parents as Teachers, or Nurse Family Partnership. (7-1-26)~~

~~**105 – 109. (RESERVED)**~~

**(BREAK IN CONTINUITY OF SECTIONS)**

**142. LM SERVICES: COVERAGE AND LIMITATIONS.**

**01. Maternity and Newborn.** Antepartum, intrapartum, and postpartum maternity and newborn care are covered. Maternal or newborn services provided after the postpartum period are not covered when provided by a Certified Professional Midwife. (7-1-26)

**02. Medication.** Covered medication listed in the LM formulary ~~under IDAPA 24.26.01.~~ (7-1-26) ( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**184. CHIS: PROVIDER QUALIFICATIONS AND DUTIES.**

CHIS are delivered by individuals who meet one (1) of the qualifying criteria below and are employed by a DDA, or who meet the criteria for enrolling as an independent CHIS provider. (7-1-26)

**01. Crisis Intervention Technician.** Crisis intervention technician is an employee of a DDA that can deliver crisis intervention directly with the eligible participant and meets the qualifications of a community-based supports staff. The technician must be under the supervision of a specialist or professional who is observing and reviewing the direct crisis intervention services performed. Supervision must occur monthly. (7-1-26)

**02. Intervention Technician.** Intervention technicians can deliver habilitative skill building, behavioral intervention, and crisis intervention. The technician must be an employee of a DDA and be under the supervision of a specialist or professional who is observing and reviewing the services performed. Supervision must occur monthly. As a provisional position status is limited to a single eighteen (18) successive month period. Providers are qualified who are working towards meeting the qualifications and competency requirements for an EBM

paraprofessional, intervention specialist, or higher.

(7-1-26)

**03. Intervention Specialist.** Intervention specialists can deliver all CHIS, complete assessments and implementation plans, and must be under the supervision of a specialist or professional who is observing and reviewing the services performed. Supervision must occur monthly. A specialist who will complete assessments or supervise an individual completing assessments must have a minimum of ten (10) hours of documented training and five (5) hours of supervised experience in completing comprehensive assessments and implementation plans for participants with functional or behavioral needs. Qualifications are as follows:

(7-1-26)

**a.** Hold a Habilitative Intervention Certificate of Completion in Idaho. These providers will be allowed to continue providing services as an intervention specialist if there is not a gap of more than three (3) successive years of employment as an intervention specialist; or

(7-1-26)

**b.** Hold a bachelor's degree from an accredited institution in a human services field or a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field; and

(7-1-26)

**i.** Can demonstrate one thousand forty (1,040) hours of supervised experience working with participants birth to twenty-one (21) years of age who demonstrate functional or behavioral needs; and

(7-1-26)

**ii.** Meets the competency requirements by completing one (1) of the following:

(7-1-26)

**(1)** A Department-approved competency checklist; or

(7-1-26)

**(2)** A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training.

(7-1-26)

**04. Intervention Professional.** Intervention professionals can deliver all CHIS and complete assessments and implementation plans. Qualifications are as follows:

(7-1-26)

**a.** Hold a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline and have a minimum of twenty-four (24) upper-division semester credits from an accredited college or university of relevant coursework in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, psychology, education, or behavior analysis ~~which may be documented within the individual's degree program, other coursework, or training;~~ and

(7-1-26) ( )

**b.** Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training.

(7-1-26)

**05. Evidence-Based Model (EBM) Intervention Paraprofessional.** EBM intervention paraprofessionals can deliver habilitative skill building, crisis intervention, and behavioral intervention, and must be supervised in accordance with the EBM. Providers must hold a para-level certification or credential in an EBM approved by the Department.

(7-1-26)

**06. Evidence-Based Model (EBM) Intervention Specialist.** EBM intervention specialists can deliver all CHIS and complete assessments and implementation plans. Specialists must be supervised according to the EBM and may supervise EBM paraprofessionals working within the same EBM. Providers must hold a bachelor-level certification or credential in an EBM approved by the Department.

(7-1-26)

**07. Evidence-Based Model (EBM) Intervention Professional.** EBM intervention professionals can deliver all CHIS and complete assessments and implementation plans. Providers must hold a masters-level degree and certification or credential in an EBM approved by the Department.

(7-1-26)

**08. Independent CHIS Provider.** Independent CHIS Providers can deliver all types of CHIS, complete assessments and implementation plans according to their provider qualification as Intervention Specialists, Intervention Professionals, EBM Intervention Specialists, and EBM Intervention Professionals. Documentation of supervision must be maintained in accordance with the Department's record retention requirements. The following

must be met: (7-1-26)

- a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; (7-1-26)
- b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; (7-1-26)
- c. Follow all applicable requirements in the CHIS sections; and (7-1-26)
- d. Not receive supervision from an individual that they are directly supervising. (7-1-26)

**09. Continuing Training Requirements.** CHIS providers must complete a minimum of twelve (12) hours of training each calendar year, including one (1) hour of ethics and six (6) hours of behavior methodology or evidence-based intervention. Continuing training requirements for new independent providers or employees of a DDA who have not provided CHIS for a full calendar year, may be prorated. (7-1-26)

**10. ~~Intervention Specialists~~ Children Birth to Three Years of Age.** Individuals acting as an intervention specialist or professional and who provide services to children birth to three (3) years of age must also demonstrate a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Individuals must have one (1) of the following: (7-1-26)(    )

- a. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or (7-1-26)
- b. A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate; or (7-1-26)
- c. This individual must have a minimum of twenty-four (24) semester credits from an accredited college or university, which can be within their bachelor's or master's degree coursework or can be in addition to the degree coursework. Courses must cover the following: (7-1-26)
  - i. Promotion of development and learning for children from birth to five (5) years of age. (7-1-26)
  - ii. Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; (7-1-26)
  - iii. Building family and community relationships to support early interventions; (7-1-26)
  - iv. Development of appropriate curriculum for young children; (7-1-26)
  - v. Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and (7-1-26)
  - vi. Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**192. PREVENTIVE HEALTH ASSISTANCE (PHA): COVERAGE AND LIMITATIONS.**

**01. Point System.** The PHA benefit uses a point system to track points earned and used by a participant. Each point equals one (1) dollar. (7-1-26)

- a. Maximum Benefit Points. (7-1-26)
- i. The maximum number of points for a Behavioral PHA is two hundred (200) each benefit year. (7-1-26)
- ii. The maximum number of points for the Wellness PHA benefit is one hundred twenty (120) each benefit year. (7-1-26)
- b. Points expire at the end of the participant's benefit year. (7-1-26)
- c. Points cannot be transferred to, or combined with, points in another participant's PHA benefit. (7-1-26)
- 02. **Weight Management Program.** Each program must provide weight management services with at least one (1) of the following: (7-1-26)
  - a. Physical fitness; (7-1-26)
  - b. Balanced diet; or (7-1-26)
  - c. Personal health education. (7-1-26)
- 03. **Premiums.** Wellness PHA benefit points are only used to offset a participant's premiums to maintain eligibility ~~under IDAPA-16-03-01~~, if applicable. Only ten (10) points may be applied per month. (7-1-26)( )

**193. PREVENTIVE HEALTH ASSISTANCE (PHA): PROCEDURAL REQUIREMENTS.**

- 01. **Behavioral PHA.** A participant must complete a PHA Benefit Agreement Form to earn two hundred (200) points. (7-1-26)
- 02. **Wellness PHA.** Each participant must demonstrate that they have received recommended wellness visits and immunizations for their age prior to earning any points. Ten (10) points can be earned each month by ~~for~~ receiving all recommended wellness visits and immunizations for their age during the benefit year. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**211. PRESCRIPTION DRUGS: PARTICIPANT ELIGIBILITY.**

All participants are eligible for prescription drug coverage. Medicaid will also pay for Medicaid-covered drugs ~~for participants with Medicare~~ that are not covered by Medicare Part D. ~~for dual eligibles~~, subject to the same limits and processes used for other Medicaid participants. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**252. THERAPY SERVICES: COVERAGE AND LIMITATIONS.**

Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, NFs, school-based services, independent practitioners, and home health agencies. (7-1-26)

- 01. **Therapy Services.** Services described in the Idaho Medicaid Provider Handbook are covered with the following limitations: (7-1-26)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (7-1-26)

b. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a provider. (7-1-26)

c. The services of therapy assistants used when providing covered benefits are included as part of the reimbursed service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services. The therapist has full responsibility for the service provided. (7-1-26)

**02. Non-Covered Therapy Services.** (7-1-26)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement or meet the criteria for a maintenance program. (7-1-26)

b. Services for developmentally acceptable error patterns. (7-1-26)

c. Services that do not require the skills of a therapy professional. (7-1-26)

d. Massage, work hardening, and conditioning. (7-1-26)

e. ~~Biofeedback, unless provided to treat urinary incontinence~~ Group hydrotherapy. (7-1-26)( )

**03. Service Limitations.** (7-1-26)

a. Therapy provided through school-based services, or the Idaho Infant Toddler Program is not included in the service limitations under this subsection. (7-1-26)

b. Maintenance therapy is covered when an individualized assessment demonstrates that skilled care is required to carry out a safe and effective maintenance program. (7-1-26)

**253. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.**

~~The Department will pay for therapy services rendered by a therapy professional if such services are ordered by a provider as part of a plan of care.~~ (7-1-26)

**01. Orders.** Services must be ordered by a qualified provider. Home health services have their own order requirements. (7-1-26)( )

~~a. Services must be reordered at least every ninety (90) days or for individuals with long term medical conditions, as documented by a provider, at least every three hundred sixty five (365) days.~~ (7-1-26)

~~b. Therapy services provided under home health must comply with the order requirements in home health instead.~~ (7-1-26)

**02. Therapy Plan of Care.** All therapy services must be provided under a therapy plan of care that is based on an evaluation and is established prior to beginning treatment. (7-1-26)

a. The plan of care must be signed by the person who established the plan and sent to the ordering provider within thirty (30) days of the evaluation to continue therapy services. (7-1-26)

b. The plan of care must be consistent with the therapy evaluation and contain: (7-1-26)

i. Diagnoses; (7-1-26)

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and

(7-1-26)

iii. Type, frequency, and duration of therapy services. (7-1-26)

c. Therapy services provided under home health must comply with the home health plan of care requirements. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**262. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.**

All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis. Participants under the age of twenty-one (21) are eligible for routine audiometric examination and testing once per calendar year, and audiometric services and supplies as follows: (7-1-26)

**01. Non-Implantable Hearing Aids.** Coverage includes; batteries purchased monthly, follow-up testing, necessary repairs not covered by warranty, the refitting of the hearing aid after the first two (2) years, and additional ear molds every six (6) months. (7-1-26)( )

**02. Implantable Hearing Aids.** The Department covers surgically implantable hearing aids when there is a documented hearing loss and non-implantable options have been tried unsuccessfully. (7-1-26)

**03. Binaural Hearing Aids.** The Department covers binaural hearing aids if documented to the Department's satisfaction, that the participant's ability to learn would be severely restricted. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**272. DMEPOS: COVERAGE AND LIMITATIONS.**

The Department will purchase, repair, or rent medically necessary DMEPOS that are suitable for use in any setting in which normal life activities take place. Department standards for medical necessity and coverage limitations are those national standards set by CMS in the CMS/Medicare DME coverage manual. Exceptions are described in the Idaho Medicaid Provider Handbook. (7-1-26)

**01. Supply Coverage.** The Department will purchase no more than three (3) months of necessary medical supplies in a three (3) month period. (7-1-26)

**02. New Equipment.** All equipment must be new at the time of purchase, or for capped rentals, at the time of dispensing. (7-1-26)

**03. Custom Fitting.** All prosthetic and orthotic devices that require fitting must be provided by a qualified provider. (7-1-26)

**04. Guaranteed Fit.** Prosthetic limbs must be guaranteed to fit properly for three (3) months from the date of service; any modifications, adjustments, or replacements within the three (3) months are included in the cost of purchase. (7-1-26)

**05. Modification and Repairs.** Modification to existing prosthetic or orthotic equipment is covered. Refitting, repairs, or additional parts are limited to once per calendar year for all prosthetics or orthotics unless documented that a major medical change has occurred to the limb. (7-1-26)

**06. Replacement Prosthesis or Orthotic Device.** Documentation as the least costly alternative to repairing or modifying the current device is required. No replacement will be allowed within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb. (7-1-26)

**07. Corsets and Braces.** Corsets and canvas braces with plastic or metal bones are not covered. Special braces enabling a participant to ambulate will be covered when a provider documents the only other method of treatment for this condition would be a cast. (7-1-26)

**08. Electronically Powered or Enhanced Prosthetic or Orthotics.** These items are non-covered. (7-1-26)

**09. Shoes and Accessories.** Shoes, accessories, and modifications are not covered except when provided for the treatment of diabetes, or when attached to an orthosis or prosthesis, or when used to provide for a totally or partially missing foot. (7-1-26)( )

**10. Temporary Lower Limb Prosthesis.** Covered when documented by the ordering provider that for the participant's rehabilitation, the prosthesis is necessary prior to a permanent limb prosthesis. A new permanent limb prosthesis will only be requested after the residual limb size is considered stable. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**322. SBS: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.**

**01. Skills Building/Community Based Rehabilitation Services (CBRS).** To be eligible for Skills Building/CBRS, the student must meet one (1) of the following: (7-1-26)

**a.** A student under eighteen (18) years of age meeting the Serious Emotional Disturbance (SED) eligibility criteria in the Children's Mental Health Services Act, Section 16-2403(135), Idaho Code. The child must experience a substantial impairment in functioning. The level and type of impairment must be documented in the school record. A Department-approved assessment must be used for an initial functional impairment score. Subsequent scores must be obtained annually to determine changes in functioning as a result of due to mental health treatment. (7-1-26)( )

**b.** A student eighteen (18) years old or older meeting the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: (7-1-26)

- i. Vocational or educational; (7-1-26)
- ii. Financial; (7-1-26)
- iii. Social relationships or support; (7-1-26)
- iv. Family; (7-1-26)
- v. Basic living skills; (7-1-26)
- vi. Housing; (7-1-26)

- vii. Community or legal; or (7-1-26)
- viii. Health or medical. (7-1-26)

**02. CHIS.** Students are eligible to receive CHIS services in accordance with EPSDT, and behavioral consultation of these rules. (7-1-26)

**03. Personal Care Services.** To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool approved by the Department that finds the student requires PCS due to a medical condition that impairs physical or functional abilities. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**325. SBS: PROVIDER QUALIFICATIONS AND DUTIES.**

Qualifications for covered services include licensure and acting within the scope of practice, where applicable. (7-1-26)

**01. Behavioral Intervention.** Provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: (7-1-26)

**a.** Intervention Paraprofessional. Provides direct services. The specialist or professional observes and reviews the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: (7-1-26)

- i. Be at least eighteen (18) years of age; (7-1-26)
- ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; (7-1-26)
- iii. Meet the paraprofessional requirements under [IDAPA 08.02.02](#). (7-1-26)

**b.** Intervention Technician. As defined for CHIS services but does not need to be the employee of a DDA. (7-1-26)

**c.** Intervention Specialist. Provides direct services, completes assessments, and develops implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: (7-1-26)

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in State Board of Education Policy Section IV.B; (7-1-26)

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019, or later, and does not have a gap of more than three (3) years of employment as an intervention specialist; or (7-1-26)

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: (7-1-26)

- (1) A Department-approved competency checklist referenced in the Idaho Medicaid Provider

Handbook; (7-1-26)

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (7-1-26)

(3) Other Department-approved competencies as defined in the Idaho Medicaid Provider Handbook. (7-1-26)

**d.** Intervention Professional. The services and qualifications for this provider type can be met by one (1) of the requirements for a CHIS intervention professional. (7-1-26)

**e.** Evidence-Based Model (EBM) Intervention Paraprofessional. As defined for CHIS services. (7-1-26)

**f.** Evidence Based Model (EBM) Intervention Specialist. As defined for CHIS services. (7-1-26)

**g.** Evidence-Based Model (EBM) Intervention Professional. As defined for CHIS services provides direct services, completes assessments, develops implementation plans, and may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. (7-1-26)

**02. Behavioral Consultation.** Must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program), and who meets one (1) of the following: (7-1-26)

**a.** An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in State Board of Education Policy Section IV.B; (7-1-26)

**b.** An individual with a Pupil Personnel Certificate who meets the qualifications defined under [IDAPA 08.02.02](#), excluding an RN or audiologist; (7-1-26)

**c.** An occupational therapist; (7-1-26)

**d.** An intervention professional; or (7-1-26)

**e.** An EBM intervention professional. (7-1-26)

**03. Crisis Intervention.** Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: (7-1-26)

**a.** An intervention paraprofessional; (7-1-26)

**b.** An intervention technician; (7-1-26)

**c.** An intervention specialist; (7-1-26)

**d.** An intervention professional; (7-1-26)

**e.** An EBM intervention paraprofessional; (7-1-26)

**f.** An EBM intervention specialist; (7-1-26)

**g.** An EBM intervention professional; (7-1-26)

**h.** A licensed physician, ~~licensed practitioner of the healing arts~~ nurse practitioner, clinical nurse

~~specialist, or physician assistant;~~ (7-1-26)( )

i. An ~~RN or~~ advanced practice ~~registered nurse~~ RN; (7-1-26)( )

j. A licensed psychologist; (7-1-26)

k. A licensed clinical professional counselor or professional counselor; (7-1-26)

l. A licensed marriage and family therapist; (7-1-26)

m. A licensed Masters social worker, licensed clinical social worker, or licensed social worker; (7-1-26)

n. A psychologist extender; (7-1-26)

~~o. An RN;~~ (7-1-26)

~~p. A licensed occupational therapist; or~~ (7-1-26)

~~q. An endorsed or certified school psychologist.~~ (7-1-26)

**04. Habilitative Skill Building.** Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following under behavioral intervention: (7-1-26)

a. An intervention paraprofessional, technician, specialist, or professional; or (7-1-26)( )

b. An EBM intervention paraprofessional, specialist, or professional; (7-1-26)( )

~~c. An EBM intervention specialist; or~~ (7-1-26)

~~d. An EBM intervention professional.~~ (7-1-26)

**05. Interdisciplinary Training.** Must be provided by one (1) of the following under behavioral intervention: (7-1-26)

a. An intervention specialist or professional; or (7-1-26)( )

~~b. An intervention professional;~~ (7-1-26)

~~c. An EBM intervention specialist or professional;~~ (7-1-26)( )

~~d. An EBM intervention professional.~~ (7-1-26)

**06. Medical Equipment and Supplies.** (7-1-26)

**07. Nursing Services.** (7-1-26)

**08. Occupational Therapy and Evaluation.** Therapy rules apply. (7-1-26)

**09. Personal Care Services (PCS).** Must be provided by or under the direction of an RN. (7-1-26)

a. ~~Providers of PCS must have~~ providers with at least one (1) of the following qualifications: (7-1-26)( )

i. Licensed ~~Registered Nurse (RN).~~ (7-1-26)( )

- ii. Licensed Practical Nurse (LPN). (7-1-26)
- iii. Certified Nursing Assistant (CNA). (7-1-26)
- iv. Personal Assistant. A person with training to ensure the quality of services who is at least eighteen (18) years of age. (7-1-26)

b. The RN must review or complete, or both, the PCS assessment and develop or review, or both, the written service plan ~~of care~~ annually. Oversight provided by the RN ~~must~~ includes all of the following: (7-1-26)( )

- i. Development of the written PCS service plan ~~of care~~; (7-1-26)( )
- ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and (7-1-26)
- iii. Reevaluation of the service plan ~~of care~~ as necessary, but at least annually. (7-1-26)( )

c. The RN must conduct quarterly supervisory visits ~~on a quarterly basis~~, or more frequently as determined by the IEP team and ~~defined as part of~~ identified in the PCS service plan ~~of care~~. (7-1-26)( )

10. **Physical Therapy and Evaluation.** Therapy rules apply. (7-1-26)

11. **Psychological Evaluation.** (7-1-26)

12. **Psychotherapy.** (7-1-26)

13. **Skills Building/Community-Based Rehabilitation Services (CBRS).** Skills Building/CBRS must be provided by one (1) of the following: (7-1-26)

a. Licensed physician, ~~licensed practitioner of the healing arts~~ nurse practitioner, clinical nurse specialists, or physician assistant; (7-1-26)( )

b. RN or Advanced practice ~~registered nurse~~ RN; (7-1-26)( )

c. Licensed psychologist; (7-1-26)

d. Licensed clinical professional counselor or professional counselor; (7-1-26)

e. Licensed marriage and family therapist; (7-1-26)

f. Licensed master's social worker, licensed clinical social worker, or licensed social worker; (7-1-26)

DOPL; g. Psychologist extender registered with ~~the Division of Occupational and professional Licenses~~ (7-1-26)( )

~~h.~~ Licensed registered nurse (RN); (7-1-26)

~~i.~~ Licensed occupational therapist; (7-1-26)

~~j.~~ Endorsed or certified school psychologist; (7-1-26)

~~k.~~ Skills Building/~~Community-Based Rehabilitation Services~~ CBRS specialist who ~~must~~ has; (7-1-26)( )

i. ~~Be an individual who has a~~ A bachelor's degree or higher and is under the supervision of a licensed

behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist monthly to review treatment provided to student participants on an ongoing basis. Supervision can be conducted using synchronous virtual care when it is equally effective as direct on-site supervision; and (7-1-26)( )

- ii. Have a credential required for CBRS specialists. (7-1-26)( )

14. **Speech/Audiological Therapy.** Therapy rules apply. (7-1-26)

15. **Social History and Evaluation.** (7-1-26)

16. **Transportation.** Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. (7-1-26)

17. **Therapy Paraprofessionals.** The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy. The portions of the treatment plan delegated to the paraprofessional must be identified in the IEP or transitional IFSP. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**340. NEMT SERVICES: DEFINITIONS.**

01. **Contracted Transportation Provider.** A provider who is under contract with the Department's transportation broker to provide NEMT for participants. (7-1-26)( )

02. **NEMT.** NEMT is transportation that is: (7-1-26)

a. Not of an emergency nature; and (7-1-26)

b. Required for a Medicaid participant to access services covered by Medicaid when the participant's own transportation resources, family transportation resources, or community transportation resources do not allow the participant to reach those services. (7-1-26)

03. **Transportation Broker.** An entity under contract with the Department to administer, coordinate, and manage a statewide network of NEMT providers. (7-1-26)

04. **Travel-Related Services.** Travel-related services are meals, lodging, and attendant care required for NEMT to be completed for a Medicaid participant. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**354. EPSDT SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**

Interperiodic and periodic medical screens must be performed by a physician, NP, or Physician's Assistant. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**461. PDN: PARTICIPANT ELIGIBILITY.**

A child's nursing needs are such that the Idaho Nursing Practice Act, Rules, Regulations, or policy require services be provided by an RN or LPN and require more individual and continuous care unavailable from Home Health nursing services. PDN is authorized by the Department prior to service delivery. Annual redetermination is required.

(7-1-26)

**01. Provider Ordered.**

(7-1-26)

a. An attending provider determines the medical status is so complex or unstable that a licensed or professional nursing assessment is needed to determine changes in medications or other interventions; or

(7-1-26)(    )

b. A determination of total PDN hours needed to ensure a child's health and safety in their home.

(7-1-26)

**02. RN Assessment.** Identifying a child's health status for unstable chronic conditions including an evaluation of the child's responses to interventions or medications.

(7-1-26)

**03. Service Plan.**

(7-1-26)

a. Developed by a multi-disciplinary team including the parent or legal guardian, the primary RN, or RN Supervisor, and a Department representative;

(7-1-26)

b. Includes all medically necessary aspects of the medical and licensed services (including PCS) to be performed (amount, type, and frequency of service) ordered by the physician;

(7-1-26)

c. Approved and signed by an attending provider, parent or legal guardian, the primary RN or RN supervisor, and a Department representative; and

(7-1-26)

d. Revised at least annually and updated as a child's needs change or upon significant change of condition, submitted to the Department for review and PA of service.

(7-1-26)

**04. Status Updates.** Must be completed every ninety (90) days from the start of services. Annual plan reviews replace fourth quarter Status Updates. Status Updates must be signed by both the parent or legal guardian and the RN supervisor completing the form.

(7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**473. NF: COVERAGE AND LIMITATIONS.**

NFs must provide regular, health-related care and services to participants who require additional care and services due to a mental or physical condition above room, board, and supervision alone.

(7-1-26)

**01. Minimum Coverage.** Minimum services and supplies include:

(7-1-26)

a. Room and board;

(7-1-26)

b. Bed and bathroom linens;

(7-1-26)

c. Nursing care, including special feeding if needed;

(7-1-26)

d. Personal services;

(7-1-26)

e. Supervision when required by the patient's condition;

(7-1-26)

f. Special diets prescribed by a ~~physician~~ provider;

(7-1-26)(    )

g. All common over-the counter medicine chest supplies;

(7-1-26)

~~h. Dressings. Applications using prescription medications or aseptic techniques must be completed by~~

~~an RN;~~ (7-1-26)

~~h.~~ Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (7-1-26)

~~j.~~ Application or administration of all drugs; (7-1-26)

~~k.~~ All common disposable medical supplies; (7-1-26)

~~k.~~ Social and recreational activities; and (7-1-26)

~~m.~~ Any reusable item commonly needed by patients expected to be available in a NF, such as bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other DME. (7-1-26)

**02. Skilled Services.** (7-1-26)

**a.** Overall development, management, and evaluation of a resident's service plan, based on a physician's orders, when a patient's physical or mental condition or aggregate PCS tasks require technical or professional staff to meet their needs, promote recovery, and assure medical safety. (7-1-26)

**b.** Ongoing assessment of rehabilitation needs concurrent with the management of a resident's service plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, ADLs, perceptual deficits, and speech, language, or hearing disorders. (7-1-26)

**c.** Professional observation and assessment of a resident's changing condition required to identify and evaluate whether treatment modification or additional medical procedures to stabilize a condition are needed. (7-1-26)

**03. Limitations.** (7-1-26)

**a.** Services requiring skilled nursing staff include: (7-1-26)

i. Intravenous injections or feedings and intramuscular or subcutaneous injections required on more than one (1) shift; (7-1-26)

ii. Nasopharyngeal feedings and aspiration; (7-1-26)

iii. Tracheotomy aspiration; (7-1-26)

iv. Catheter insertion, sterile irrigation, and replacement; (7-1-26)

v. Treating extensive decubitus ulcers or other widespread skin disorders; (7-1-26)

vi. Heat treatments specifically ordered by a ~~physician~~ provider as part of treatment and requiring nurse observation to adequately evaluate a resident's progress; and (7-1-26)( )

vii. Initial phases of a regimen involving oxygen administration. (7-1-26)

**b.** Services requiring physical or occupational therapists include: (7-1-26)

i. Therapeutic exercises or activities must be performed by or under supervision to ensure resident safety and treatment effectiveness; (7-1-26)

ii. Gait evaluation and training to restore function in a resident whose ability to walk is impaired by neurological, muscular, or skeletal abnormality; (7-1-26)

iii. Ultrasound, short-wave, and microwave therapy treatments; and (7-1-26)

iv. Other treatment and modalities including hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool for residents with circulatory deficiency, desensitization, open wounds, fractures, or other complications. (7-1-26)

**04. Date of Discharge.** The day a participant is released is not a day of care. ( )

**474. NF: PROCEDURAL RESPONSIBILITIES.**

Each NF administrator, or their authorized representative, must report the following information to the Department within three (3) working days of the date a NF is aware of: (7-1-26)( )

**01. Change of Status.** Any participant readmission, discharge, or any temporary absence due to hospitalization or therapeutic home visit. (7-1-26)

**02. Changes of Resident's Income.** (7-1-26)

**03. Amount Exceeded.** When a resident's account exceeds one thousand eight hundred dollars (\$1,800) for single participants, or two thousand eight hundred dollars (\$2,800) for married couples. (7-1-26)

**04. Other Patient Financial Information.** Other information about a resident's finances that potentially affects eligibility for Medicaid. (7-1-26)

**475. PREADMISSION SCREENING AND RESIDENT REVIEW PROGRAM (PASRR).**

NFs must assure that all screens are obtained and coordinated with the Department, independent mental illness (MI) evaluators, the State Mental Health Authority (SMHA) and State Intellectual Disabilities or Developmental Disabilities Authority (SDDA), and designees. (7-1-26)

**01. Level I Screening.** All required Level I screens and level of care reviews are completed and submitted to the Department prior to NF admission. (7-1-26)

**02. Level II Screening.** When a NF identifies an individual with MI or DD (typically through a Level I screen), they must contact the SMHA or SDDA (as appropriate), and to complete a Level II screen prior to admission, or for existing residents, to continue residing in the NF. (7-1-26)

**03. Change in Status.** Resident reviews for residents with MI or DD must occur and a new determination made after any significant change in their physical or mental condition renders them incapable of responding to program interventions. NFs must notify the Department of any changes within ~~two~~ fourteen (214) ~~working~~ days of occurrence when any significant change requires new or increased specialized services. (7-1-26)( )

**04. Exceptions to PASRR.** The NF bears the burden of documenting that applicable criteria are met. No exception under this section eliminates Section 475.03 requirements. ( )

**a. Level II screening is not required when:** ( )

**i. Admission is directly from a hospital after acute inpatient care;** ( )

**ii. Services are for the same condition treated in the hospital; and** ( )

**iii. The attending physician certifies prior to admission that care is likely needed for fewer than thirty (30) days.** ( )

**b. If more than thirty (30) days of care are necessary, the NF must submit the Level I screen and level of care review to the Department and the SMHA or SDDA must complete the Level II screening within forty (40) calendar days of admission.** ( )

**c. A PASRR is not required for readmission directly from a hospital the participant was transferred to**

for care. An annual resident review is still required. ( )

d. Screening is not required when the participant transfers from another NF. Instead, the transferring NF provides copies of the most recent PASRR and resident assessment. An annual resident review is still required. ( )

e. The SMHA or SDDA can make advance categorical determinations that NF services are necessary when: ( )

i. Short-term recuperative care following acute physical illness requiring hospitalization is necessary, and the admission does not qualify as an exempted hospital discharge under 475.04.a. A Level II Screening must be initiated before day one hundred twenty (120) if continued NF care is required. ( )

ii. Admission is for palliative or end-of-life care and the participant is eligible for hospice services. ( )

iii. The attending physician documents a participant's physical condition precludes meaningful participation in a Level II evaluation at admission. A Level II assessment is necessary within forty (40) calendar days of admission or when the individual's condition permits, whichever is earlier. ( )

iv. Delirium at admission prevents accurate MI or DD diagnosis. A Level II assessment must be initiated within fourteen (14) days of admission. ( )

v. Delay for preadmission screening would jeopardize the individual's health or safety. The NF must notify the Department within twenty-four (24) hours of admission. A Level II is necessary within seven (7) calendar days of admission if the Level I screen is positive for MI or DD. ( )

05. Reimbursement During Exempted or Delayed Level II Admissions. Medicaid reimbursement is available from the date of admission when all applicable criteria and documentation requirements are met under Subsections 475.04.a. through 04.e. Where a Level II evaluation is delayed under Subsections 475.04.e.iii, iv., or v., reimbursement is available only through the day before the assessment deadline, and then after the assessment is completed. For admissions under Subsection 475.04.a., if NF care extends beyond thirty (30) days without a timely resident review, reimbursement is not available for days of care furnished before the resident review is completed. ( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**486. NF: DISTRESSED FACILITY.**

**01. Department Determination.** NFs in an under-served area, or addressing an under-served need, may receive an alternative rate. (7-1-26)

**02. Discretionary Factors.** A NF is not guaranteed increased payment. The Department considers factors for a higher rate on a NF-by-NF basis: (7-1-26)

**a.** Prudent spending patterns and cost allocation as evidenced by a Department review of the NF's accounts. (7-1-26)

**b.** A NF diligently attempted to cover costs of care, hire qualified staff, and otherwise operate effectively and efficiently, but cannot due to causes beyond the NF's reasonable control. (7-1-26)

**c.** The same costs of care used to determine special rates are not applied toward a determination of distressed facility status. (7-1-26)

**d.** The determination of distressed status focuses on whether the NF's distress stems from patient care

costs, and not expenses unrelated to patient care costs. (7-1-26)

e. A NF's payment cannot exceed the lower of its actual costs or customary charge to private-pay patients unless ~~except~~ exempt by federal law. The Department's cost caps can be exceeded through the distressed facility process up to the federal UPL. (7-1-26)(    )

**03. Annual Review.** Distressed facility payments are short-term and redetermined for each fiscal year a NF requests a distressed facility rate. (7-1-26)

**04. Prospective Application.** Only NFs currently distressed or entering a period of distress are eligible. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**488. NF: BEHAVIORAL CARE UNIT (BCU) RATES.**

**01. Direct Care Costs.** Additional direct care costs for BCU residents remain in direct care costs subject to the direct care cost limitation. Qualifying BCU NFs may have a direct care cost limitation higher than non-BCU NFs, and do not receive an increased indirect care cost limitation. (7-1-26)(    )

**02. New Owner.** The prior owner's cost report is used for rate calculations until the new owner has a qualifying cost report. The BCU continues to qualify for the same higher direct care cost limit as the previous owner. If the BCU is discontinued, the direct care cost limit is adjusted down to match a non-BCU NF. (7-1-26)

**489. NF: BCU QUALIFICATIONS.**

~~Facilities must meet the qualifications for a BCU described in the Idaho Medicaid Provider Agreement Additional Terms—Behavioral Care Units.~~ (7-1-26)

~~**490. NF: BCU ELIGIBLE DAYS.**~~

NFs adding a BCU must demonstrate BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same 60-day period, equals or exceeds a minimum of thirty percent (30%). (7-1-26)(    )

**490. (RESERVED)**

**491. NF: SPECIAL RATES.**

The Department pays NFs an addition to their daily rate when a patient's needs exceed the scope of NF services, and the cost is not adequately reflected in the calculated rates. This rate is in addition to any payments under other provisions and excluded from the computation of payments or rates under other sections of these rules. (7-1-26)

**01. Determination.** The Department approves special rates per patient based on identified conditions expected to continue for more than thirty (30) days. No rate is allowed if payment for these needs is available from a non-Medicaid source. (7-1-26)

**02. Effective Date.** Upon approval, a special rate is effective on the date set by the Department. (7-1-26)

**03. Reporting.** Costs equivalent to payments for special rate add-on amounts are removed from cost components subject to limits and reported separately. (7-1-26)

**04. Limitation.** Special rates cannot exceed a NF's charges to other patients for similar services. (7-1-26)

**05. Prospective Rate Treatment.** Special rates are paid under a prospective payment system. (7-1-26)

**06. Payment for Qualifying Residents.** The Department calculates special rate add-on amounts using one (1) of the following methods: (7-1-26)

**a.** For NFs operating as a one hundred percent (100%) special care unit including Medicaid residents, the direct care cost per diem is not subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of a NF's Medicaid CMI for the rate period to the NF-wide CMI for the cost reporting period. (7-1-26)

**b.** ~~The Department pays for equipment and non-therapy supplies not addressed in the coverage and limitations section in accordance with DMEPOS, as an add-on amount.~~ Weighted Average Hourly Rate (WAHR) rates are calculated using an annual survey of all Idaho NFs and ICFs/IID to establish the WAHR for Idaho NF employees in comparable positions multiplied by a supplemental component composed of costs reported for travel, administration, training, and all payroll taxes and fringe benefits collected during the most recent State Fiscal Year. (7-1-26)( )

**c.** NFs providing care to residents who are ventilator-dependent or receive tracheostomy care are eligible to submit requests for a fixed add-on amount, in addition to the NF's rate for residents receiving this type of care. Approved requests are effective the date a resident needs this care, no earlier than sixty (60) days prior to request receipt. Add-on rates include the cost for equipment and supplies and for additional RN and CNA hours, as appropriate for each care type. Costs for equipment and supplies are adjusted annually for inflation, and skilled nursing costs are adjusted according to annual WAHR survey results. (7-1-26)

**i.** The Department reviews approved add-on rates for these residents annually to ensure the add-on rate remains necessary for the resident's care needs. (7-1-26)

**ii.** NFs must inform the Department when an approved add-on rate is no longer needed or a resident's special needs change. (7-1-26)

**iii.** The hourly add-on rate for staffing in an out-of-state NF equals the current WAHR CNA or RN wage rate plus a benefits allowance based on annual cost report data and weighted to remove CNA minimum daily staffing time adjusted for the appropriate staff skill level. (7-1-26)

**07. Treatment of Special Rates In Future Rate Setting Periods.** Special rates are established on a prospective basis as with the overall NF rate. When a cost report used to set rates contains a special add-on cost, the Department makes an adjustment to reduce costs by an amount equal to total incremental revenues, or add-on payments received by the NF during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days paid. No related adjustment is made to the NF's CMIs. (7-1-26)

**08. Special Rate for NF Ownership Change or Closure.** The Department does not require a closing cost report, and reviews special rates made in the closing cost reporting period. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**502. ICF/IID: COVERAGE AND LIMITATIONS.**

The Department pays for services in an ICF/IID whose primary purpose is providing habilitative services and maintaining optimal health status for individuals with intellectual disabilities or related conditions. (7-1-26)

**01. Coverage.** The minimum content of care and services for ICF/IID residents includes: (7-1-26)

**a.** Room and board; (7-1-26)

**b.** Bed and bathroom linens; (7-1-26)

**c.** Nursing care, including special feeding if needed; (7-1-26)

- d.** Personal services; (7-1-26)
- e.** Supervision; (7-1-26)
- f.** Special diets as prescribed by a participant's provider; (7-1-26)
- g.** All common medicinal supplies that do not require a prescription; (7-1-26)
- h.** Dressings; (7-1-26)
- i.** Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; (7-1-26)
- j.** Application or administration of all drugs; (7-1-26)
- k.** All medical supplies; (7-1-26)
- l.** Social and recreational activities; and (7-1-26)
- m.** Items used by individuals that are reusable and expected to be available. (7-1-26)

**02. Limitations.** Specialized wheelchairs and seating systems, including repair, designed to fit the needs of a specific resident and cannot be altered to fit another resident cost effectively are not included in ICF/IID content of care. These are paid directly to the supplier. (7-1-26)

**03. Temporary Absence.** Reimbursement is available for reserving beds ~~for~~ during a temporary absence, if the facility charges private payors for reserve bed days. Therapeutic home visits are allowed for up to thirty-six (36) days per calendar year when days are part of a written treatment plan ordered by the attending physician. Prior authorization is required for any home visits exceeding fourteen (14) consecutive days. Reimbursement is the lesser of audited allowable costs, or usual and customary charges. (7-1-26)( )

**503. ICF/IID: PROCEDURAL RESPONSIBILITIES.**

**01. Reporting Requirements.** Each ICF/IID administrator, or their authorized representative, must report to the Department within three (3) working days of the date the facility is aware of the following: (7-1-26)

- a.** Readmissions or discharges, including any participant's temporary absence due to hospitalization or therapeutic home visit. (7-1-26)
- b.** Changes to participant's income. (7-1-26)
- c.** Participant's account exceeds one thousand eight hundred dollars (\$1,800) for single individuals or two thousand eight hundred dollars (\$2,800) for married couples. (7-1-26)
- d.** Other changes to participant's finances that may potentially affect their eligibility for Medicaid. (7-1-26)

**02. Annual Recertification.** ICF/IIDs must assure that participant annual recertifications are completed. (7-1-26)

**a.** When Medicaid receives a federal financial penalty due to the lack of appropriate recertification on the part of an ICF/IID, then that amount is withheld from facility payments for participants. For audit purposes, these financial losses are not a reimbursable cost of participant care and cannot be billed to the participant. (7-1-26)

**b.** ICF/IID residents are transitioned to a less restrictive environments within thirty (30) days of a determination when a participant fails to meet ICF/IID level of care. (7-1-26)( )

**03. Supplemental On-Site Visit.** The Department conducts utilization control supplemental on-site visits in an ICF/IID to review these indications to complete follow-up activities, verify a participant's appropriateness of placement or services, and conduct complaint investigations. (7-1-26)

**04. Determinations.** The Department issues the final decision for eligibility and level of care, including the need for DD or MI active treatment through the Level II screening process. If eligible, the Department forwards authorization for payment to the facility chosen by the individual. The participant can select any certified facility to provide care. No payment is made to any facility for services that are beyond the facility's licensed level of care. (7-1-26)

**504. ICF/IID: PROVIDER QUALIFICATIONS AND DUTIES.**

**01. Direct Care Staffing Levels.** ~~A reasonable level of direct care staff provided to an ICF/IID resident is dependent upon the level of involvement and their need for services and supports as determined by the Department. Level of involvement relates to the severity of a resident's intellectual disability. Those levels, in decreasing level of severity, are profound, severe, moderate, and mild.~~ Direct care staffing levels are limited to the following maximum hours per week: (7-1-26)( )

**a.** Sixty-eight and twenty-five hundredths (68.25) hours for a severely and profoundly intellectually disabled resident. (7-1-26)

**b.** Fifty-four and six tenths (54.6) hours for a moderately intellectually disabled resident. (7-1-26)

**c.** Thirty-four and one hundred twenty-five thousandths (34.125) hours for a mildly intellectually disabled resident. (7-1-26)

**02. Direct Care Staff Hours.** The annual sum level of allowable direct care staff hours for each residential living unit is determined in the aggregate as the sum total of the level of staffing allowable for each resident. (7-1-26)

**03. Phase-In Period.** If these rules require a facility to reduce its direct care staffing, a six (6) month phase-in period is allowed from the date of adjustment, without any resulting disallowances. Should disallowances result, the hourly rate of direct care staff used in determining disallowances is the weighted average of the hourly rates paid to the direct care staff, plus associated benefits, at the end of the phase-in period. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**537. HCBS: CONFLICT OF INTEREST.**

Providers must disclose any household or familial relationship between a participant and an owner, partner, officer, director, managing employee, or person with a controlling interest in the agency. The Department may deny or revoke authorization for such arrangements when necessary to prevent conflicts of interest, ensure program integrity, or protect participant choice and health and welfare. ( )

**538. (RESERVED)**

**(BREAK IN CONTINUITY OF SECTIONS)**

**540. A&D WAIVER SERVICES: DEFINITIONS.**

**01. A&D Waiver Services.** Services for the elderly and physically disabled to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like or community-based setting. It does not include participants in skilled, or intermediate care facilities, nursing facilities, ICF/IID or

hospitals. When possible, services should be available in the participant's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports. (7-1-26)

**02. Employer of Record.** An entity that bills for services, withholds required taxes, and conducts other administrative activities for a waiver participant. Such an entity is also called a PAA functioning as a fiscal intermediary (FI). (7-1-26)

**03. Employer of Fact.** A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver provider. This individual may be a family member. (7-1-26)

**04. Fiscal Intermediary.** An entity that provides services allowing the participant receiving waiver services, their designee, or legal representative, to choose their level of control to recruit, select, manage, train, and dismiss direct care staff regardless of the employer of record, and allows the participant control over their service delivery. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**542. A&D WAIVER SERVICES: COVERAGE AND LIMITATIONS.**

Waiver services are provided to prevent institutional placement, provide for the greatest degree of independence possible, enhance quality of life, encourage individual choice, and achieve and maintain community integration. (7-1-26)

**01. Adult Day Health.** Supervised, structured services provided outside the participant's home in a non-institutional, community-based setting, and encompassing health and social services, recreation, supervision for safety, and assistance with ADL needed to ensure optimal function of the participant. Services do not include room and board payments. (7-1-26)

**02. Adult Residential Care.** A range of services provided in a homelike, noninstitutional setting that includes licensed Residential Assisted Living Facilities and CFHs. Administrative oversight must be provided for all services provided or available in these settings. Payment does not include room and board. ~~The number of residents in a setting is limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department.~~ Services are provided in a congregate setting and include: (7-1-26)( )

- a. Medication assistance, to the extent permitted under State law; (7-1-26)
- b. Assistance with ADL; (7-1-26)
- c. Meals, including special diets; (7-1-26)
- d. Housekeeping; (7-1-26)
- e. Laundry; (7-1-26)
- f. Transportation; (7-1-26)
- g. Opportunities for socialization for ~~participants in a~~ RALF residents; (7-1-26)( )
- h. Recreation; and (7-1-26)
- i. Assistance with personal finances. (7-1-26)

**03. Specialized Medical Equipment and Supplies.** (7-1-26)

a. Devices, controls, or appliances enabling a participant to increase their abilities to perform ADL, or to perceive, control, or communicate with the environment in which they live; and (7-1-26)

b. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and DME and non-DME not available under State Plan or EPSDT. (7-1-26)

04. **Non-Medical Transportation (NMT).** Transportation enabling a participant to access waiver and other community services and resources. Whenever possible, non-paid supports or public transit providers are used. (7-1-26)

05. **Attendant Care.** Services involving tasks ~~dealing with the~~ related to a participant's functional needs ~~of the participant~~ and accommodating their ~~needs for~~ long-term maintenance, supportive care, or ADL needs. These services include ~~personal assistance~~ PCS and medical tasks ~~that can~~ able to be done by unlicensed persons or delegated to ~~an~~ unlicensed person s by a licensed health care professional or the participant. Services are based on a participant's abilities and limitations, regardless of age, medical diagnosis, or other ~~category of~~ disability. Assistance may be hands-on ~~assistance~~ or prompts to perform a task. (7-1-26)(    )

06. **Chore Services.** Include intermittent assistance or chore activities when necessary to maintain functional use of the participant's home or to provide a clean, sanitary, and safe environment. Services are only available when neither the participant, nor anyone else in the home, is ~~capable of~~ able to performing or financially ~~providing~~ provide for them, and when no other non-paid support, landlord, agency, or third-party payer is ~~required or~~ willing ~~or~~ and able to provide. Services are limited to those provided in a home rented or owned by the participant. For rental property, the Department examines ~~the~~ lease agreements s for landlord responsibilities prior to any authorization of service. (7-1-26)(    )

07. **Companion Services.** In-home services ~~that include~~ including non-medical care, supervision, and socialization provided to ~~a functionally impaired adult ensuring~~ ensure the safety and well-being of a ~~person~~ participant who cannot be left alone due to their condition. The provider may live with a participant. The provider may ~~provide~~ use cuing and occasional assistance with ADL and perform light housekeeping tasks ~~that are~~ incidental to the care and supervision of the participant, but the primary responsibility is to provide companionship and to be accessible in case of emergency. (7-1-26)(    )

08. **Consultation (Self-Direction).** Services provided by a PAA to a participant or family member to increase their skills as an employer or manager of their own care. Services are directed at achieving the highest level of independence and self-reliance possible for the participant and ~~the participant's~~ their family by consulting with the participant and family to gain a better understanding of the ~~special~~ participant's needs ~~of the participant~~ and the caregiver role ~~of the caregiver~~. (7-1-26)(    )

09. **Home-Delivered Meals.** Meals delivered to the participant's home that promote adequate nutrition. Participants can receive one (1) to two (2) meals per day when they rent or own a home, are alone for extended periods with no caregiver, and are unable to prepare a meal without assistance. (7-1-26)

10. **Homemaker Services.** Performing for or assisting the participant with essential errands and other routine housekeeping duties when no one else in the household ~~is capable of performing~~ can perform these tasks. (7-1-26)(    )

11. **Environmental Accessibility Adaptations.** Minor housing adaptations necessary for a participant to function with greater independence in their home, or without which, would require institutionalization or pose a risk to health, or safety including: (7-1-26)

a. Installations or modifications necessary to accommodate medical equipment and supplies necessary for the participant's health and safety ~~of the participant~~ but excludes those that are not of direct medical or remedial benefit to the participant. (7-1-26)(    )

b. Unless otherwise authorized, permanent modifications are limited to the participant's principal residence that is owned by the participant or their non-paid family. (7-1-26)

c. Portable or non-stationary modifications may be made when a participant or their non-paid family rents a home, and modifications follow a participant to their next residence. (7-1-26)

12. **Personal Emergency Response System (PERS).** Electronic devices enabling participants to secure help in an emergency which connects to a participant's phone and is programmed to signal a response center when activated. The response center is staffed by trained professionals. PERS is limited to participants who rent or own a home, or live with unpaid caregivers, are alone for extended periods with no caregiver, and require extensive, routine supervision. (7-1-26)

13. **Respite-Care.** Short-term breaks from caregiving responsibilities to non-paid caregivers. The caregiver or participant selects, trains, and directs the provider. While receiving respite-care, participants cannot receive other duplicative services. Respite-care does not include room and board payments. Services may be provided in a participant's residence, CFH, DDA, RALF, or ADH facility. (7-1-26)( )

14. **Skilled Nursing.** Intermittent or continuous oversight, training, or skilled care within the scope of the Nurse Practice Act provided by an RN or LPN under the RN's supervision-of an RN. Services cannot be less cost-effective than a Home Health visit. (7-1-26)( )

15. **Residential Habilitation.** Habilitation services to help an individual acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity, and includes training in one of the following: (7-1-26)

- a. Self-direction; (7-1-26)
- b. Money management; (7-1-26)
- c. Daily living skills; (7-1-26)
- d. Socialization not including participation in non-therapeutic activities that are diversional or recreational in nature; (7-1-26)
- e. Mobility; (7-1-26)
- f. Behavior shaping and management. (7-1-26)
- g. Personal assistance servicesPCS that assist an individual in ADL, household tasks, and other routine activities as the participant or their primary caregivers are unable to accomplish-on their own behalf themselves. (7-1-26)( )
- h. Skills training to teach participants and supports to perform activities with greater independence and to reinforce habilitation training. (7-1-26)

16. **Day Habilitation.** Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills-that take place in a non-residential setting. Services focus on enabling the participant to attain or maintain their maximum functional level and are coordinated with any physical, occupational, or speech-language therapy services listed in the service plan-of care. Services may reinforce skills taught in school, therapy, or other settings. (7-1-26)( )

17. **Supported Employment.** Competitive work in integrated work settings for individuals for whom competitive employment has not traditionally occurred, or when competitive employment is interrupted or intermittent due to severe disability. The nature and severity of an individual's disability requires intensive supported employment services or extended services for them to work. This service is not available when funded under another program. (7-1-26)

18. **Transition Services.** Goods and services enabling a participant residing in a NF, hospital, IMD, or ICF/IID to transition to a community-based setting immediately following discharge from a qualified institution after a minimum of forty-five (45) days. Authorization is only allowed when a participant is unable to meet an expense or obtain supports from other sources. (7-1-26)( )

- a. Services may include: (7-1-26)
  - i. Security deposits required to obtain a lease on an apartment or home; (7-1-26)
  - ii. Cost of essential household furnishings; (7-1-26)
  - iii. Set-up fees or deposits for utility or service access; (7-1-26)
  - iv. Services necessary for health and safety prior to occupancy; (7-1-26)
  - v. Moving expenses; and (7-1-26)
  - vi. Activities to assess need, arrange for, and procure transition services. (7-1-26)
- b. Exclusions. Ongoing expenses (including utilities), real property, décor, or entertainment and recreational items. (7-1-26)
- c. Limitations. ~~A total cost of two thousand dollars (\$2,000) per participant and Assistance is only accessed available once every two (2) years for up to two thousand dollars (\$2,000), following a qualifying transition. Services are furnished when a participant is unable to meet an expense or when a support cannot be obtained from other sources.~~ (7-1-26)( )

**19. A&D Case Management.** To assist participants with gaining and coordinating access to necessary care and services appropriate to the needs of the individual ~~and may include crisis hours.~~ (7-1-26)( )

**543. A&D WAIVER SERVICES: PROCEDURAL REQUIREMENTS.**

**01. Individual Service Plan.** The Department administers the assessment and develops the initial ~~individual~~ service plan. The Department reviews and approves all ~~individual~~ service plans based on information from the assessment and any other medical information ~~that verifies~~ verifying the need for services, and authorizes services by type, scope, and amount. All ~~individual~~ service plans must meet HCBS person-centered planning requirements. (7-1-26)( )

a. Services not in the ~~individual~~ service plan or exceeding those approved by the Department are not eligible for Medicaid payment. (7-1-26)( )

b. The earliest services can be approved is ~~on~~ the date ~~an individual~~ a service plan is signed by the participant or their designee. (7-1-26)( )

c. All services ~~that are provided~~ must be based on a documented service plan. (7-1-26)( )

d. A new plan must be developed and approved annually. (7-1-26)

e. The plan may be adjusted during the year with an addendum. ~~These a~~ Adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment is subject to Department PA. (7-1-26)( )

**02. Provider Records.** (7-1-26)

a. Providers must document each visit ~~made~~ or service provided to the participant, and record the following: (7-1-26)( )

i. Service date; (7-1-26)

ii. Services provided; (7-1-26)

iii. Statement of participant's response to services when applicable, including any changes in their

condition; and (7-1-26)

iv. Length of visit, including ~~time in and out~~ start and end times. Unless the Department determines a participant is unable to, service delivery is verified by the participant by signing a service record. (7-1-26)( )

b. Providers must maintain service delivery records accessible to participants. (7-1-26)

c. The ~~individual~~ service plan must be available to all providers and the Department. The individual service plan and assessment are available from the Department for providers with a release of information signed by the participant or legal representative. (7-1-26)( )

d. EVV Systems do not replace documentation requirements but may be used to generate documentation. (7-1-26)

03. **Provider Notification.** Providers must document in the service record and notify the Department, medical provider, A&D or MCO case manager, and family when any significant changes occur in the participant's condition ~~are noted~~. (7-1-26)( )

#### 544. A&D WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. **Employment Status.** Unless otherwise specified by the Department, each ~~individual~~ service provider must be an agency employee ~~of an agency~~. The Department may enter into provider agreements with individuals in situations when no agency exists, or no FI is willing to provide services. Such agreements are reviewed annually to verify whether agency coverage ~~by a PAA or FI~~ is still not available. (7-1-26)( )

02. **Fiscal Intermediary Services (FI).** An FI providing Consultation services supporting self-direction must: (7-1-26)

a. Assure compliance with legal requirements related to employment of ~~providers~~ DCWs; (7-1-26)( )

b. Offer supportive services to enable participants or their families to perform the required employer tasks themselves; (7-1-26)

c. Bill Medicaid for ~~services~~ Department-authorized ~~by the Department~~ services; (7-1-26)( )

d. Collect any ~~participant participation due~~ share of cost; (7-1-26)( )

e. Pay providers for service; (7-1-26)

f. Perform all necessary withholding as required by state and federal regulations; (7-1-26)

g. Assure that ~~providers~~ DCWs meet the required standards and qualifications; (7-1-26)( )

h. Maintain liability insurance coverage; (7-1-26)

i. Conduct annual participant satisfaction or quality control reviews made available to the Department and the public; and (7-1-26)

j. Obtain required background checks and health screens on ~~employees~~ DCWs. (7-1-26)( )

03. **Provider Qualifications.** Providers of homemaker, respite ~~care~~, ADH, transportation ~~NMT~~, chore services, companion services, attendant care, adult residential care, A&D ~~C~~ase ~~M~~anagement, residential habilitation, and home-delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's A&D waiver as approved by CMS. Persons aged sixteen (16) or seventeen (17) must also be, or working towards, a CNA to qualify as DCWs. ~~Direct care workers~~ DCWs cannot be a participant's spouse.

(7-1-26)( )

**04. Quality Assurance (QA).** Providers must respond to QA reviews within forty-five (45) days of receiving results. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (7-1-26)

**05. Specialized Medical Equipment and Supplies.** Must be enrolled with Medicaid as a supplier. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference is given to the most cost-effective option to meet a participant's needs. (7-1-26)

**06. Consultation Services.** Must be provided ~~through~~ by a PAA by a person with demonstrated skills in training participants/family members to hire, fire, train, and supervise their own ~~care providers~~ DCWs. (7-1-26)( )

**07. Adult Residential Care.** Must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. (7-1-26)

**08. Home-Delivered Meals.** (7-1-26)

**a.** Each meal meets one third (1/3) of the Recommended Daily Allowance, as defined by the United States Department of Agriculture (USDA); (7-1-26)

**b.** Meals are delivered under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (7-1-26)

**c.** Maintain Ddocumentation ~~is maintained~~ demonstrating that ~~the~~ meals served are made from the highest USDA grade for each specific food served; and (7-1-26)( )

**d.** A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. (7-1-26)

**09. PERS.** Must demonstrate that devices installed in a participant's home meet Federal Communications Commission (FCC) standards. (7-1-26)

**10. Adult Day Health.** (7-1-26)

~~**a.** Providers must notify the Department for the participant when the service is provided in a CFH other than the participant's primary residence.~~ (7-1-26)

~~**b.** Providers m~~Must be free from communicable disease. (7-1-26)( )

**11. Non-Medical Transportation.** Possess a valid driver's license and vehicle insurance. (7-1-26)

**12. Attendant Care and Homemaker.** Must be employees of ~~an agency~~ a PAA. (7-1-26)( )

~~**13. Homemaker Services.** Must be employees of an agency.~~ (7-1-26)

~~**14.**~~ **143. Environmental Accessibility Adaptations.** Must meet applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (7-1-26)

~~**15.**~~ **154. Residential Habilitation.** Employment by a certified residential habilitation agency. ~~Prior to delivering services, complete an orientation program and additional training requirements must be completed within six (6) months of employment.~~ (7-1-26)( )

~~**16.**~~ **165. Day Habilitation.** Employed by a certified residential habilitation agency. Prior to delivering services, staff must complete an orientation program and complete additional training within six (6) months of employment. (7-1-26)

**176. Respite-Care.** Receive instructions in the participant's needs, demonstrate the ability to follow ~~the~~ a service plan, and be free of communicable disease. (7-1-26)( )

**187. Supported Employment.** ~~Provided~~ Employed by an agency that meets State requirements. (7-1-26)( )

**198. Chore Services.** Be skilled in the service ~~to be~~ provided; and demonstrate the ability to follow a service plan. (7-1-26)( )

**2019. Transition Services.** Transition managers employed by a PAA or service coordination agency. (7-1-26)( )

**210. A&D Case Management.** Case ~~M~~anagers ~~must be~~ employed by an PAA or service coordination agency ~~that is not an FI.~~ Case ~~M~~anagers may not provide other direct services. (7-1-26)( )

**545. A&D WAIVER SERVICES: PROVIDER REIMBURSEMENT.**

**01. Rates.** ~~Reimbursement for services~~ Payment includes both services and mileage. Mileage for ~~provider~~ DCW transportation to and from the service delivery location is not reimbursable. (7-1-26)( )

**02. Electronic Visit Verification (EVV) Compliance.** Claims for Attendant Care, Homemaker, and Respite ~~services~~ provided by a PAA require EVV compliance to be reimbursable. (7-1-26)( )

**546. – 548. (RESERVED)**

**SUB AREA: TRANSITION MANAGEMENT  
(Section 549)**

**549. TRANSITION MANAGEMENT.**

Provides relocation assistance and intensive service coordination activities to assist NF, hospital, IMD, and ICF/IID residents to transition to community settings of their choice. Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community, functioning as a liaison between the participant, institutional or facility discharge staff, and other individuals identified by the participant. Participants are eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) days. (7-1-26)

**01. Provider Qualifications.** Transition managers must: (7-1-26)

**a.** Successfully complete ~~of~~ a Department-approved Transition Manager training prior to providing any transition management or transition services; (7-1-26)( )

**b.** Have a Bachelor's degree in a human services field or three (3) years' supervised work experience with the population served; and (7-1-26)

**c.** Be employed by an agency. (7-1-26)

**02. Service Description.** Includes the following activities: (7-1-26)

**a.** A comprehensive assessment of health, social, and housing needs; (7-1-26)

**b.** Development of housing options, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; (7-1-26)

**c.** Assistance with tasks necessary to accomplish a move from the institutional setting; (7-1-26)

**d.** Securing Transition Services to coordinate the move, including: (7-1-26)

- i. Obtaining DME, assistive technology, and medical supplies; (7-1-26)
  - ii. Arranging for home modifications; (7-1-26)
  - iii. Applying for public assistance; or (7-1-26)
  - iv. Arranging household preparations including scheduling moving or cleaning services, utility set-up, purchasing furniture, and household supplies. (7-1-26)
  - e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; and (7-1-26)
  - f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, post-secondary educational institutions and proprietary schools, and community inclusion. (7-1-26)
- 03. Limitations.** Transition management is limited to seventy-two (72) hours per participant per qualifying transition. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**551. PCS: ELIGIBILITY.**

- 01. ~~Level of Care~~Assessment.** The Department conducts an assessment to determine whether a participant's medical condition impairs their physical or mental functions or independence, and whether they can remain safely and effectively in their personal residence when supported by authorized PCS. (7-1-26)(      )
- 02. Redetermination.** Required annually to reauthorize PCS or to refer a participant to a NF. (7-1-26)
- 03. Significant Changes.** An assessment can be requested due to changes in a participant's needs at any time. (7-1-26)

**552. PCS: COVERAGE AND LIMITATIONS.**

- 01. Medical Care and Services.** Tasks related to a participant's physical or functional requirements provided in the participant's personal residence including assistance with: (7-1-26)
- a. Basic personal care and grooming; (7-1-26)
  - b. Bladder or bowel routines or requirements; (7-1-26)
  - c. Food, nutrition, and diet activities; (7-1-26)
  - d. Continuation of at home active treatment programs to increase or maintain independence for participants with DD; (7-1-26)
  - e. Physician-ordered medications ordinarily self-administered; (7-1-26)
  - f. Non-nasogastric gastrostomy tube feedings that meet the following requirements: (7-1-26)
    - i. Non-complex tasks that can be safely performed in a participant's location; (7-1-26)
    - ii. An RN assessed a participant's needs and developed a written procedure according to a participant's individualized needs; (7-1-26)(      )

iii. An RN delegates by name who can perform this procedure only after an individual demonstrates safe performance of the individualized procedure. RNs must document the strengths and weaknesses of any delegates, and evaluate their performance monthly; (7-1-26)

iv. Delegates must report any change in participant status or problems with the procedure immediately to the RN; (7-1-26)

v. The supervisor RN maintains documentation of the individualized procedure, the supervised performance of the procedure, and follow-up evaluations of delegates readily available for review, in the participant's record; and (7-1-26)

vi. ~~Direct care workers~~ DCWs only give routine medication through a non-nasogastric tube as authorized by a supervisor RN. (7-1-26)( )

**02. Non-Medical Care and Services.** Includes the following tasks, when no natural supports are available: (7-1-26)

a. Minimal housekeeping tasks incidental to the delivery of an ADL care task essential to participant comfort or health and excludes services for any other residents. (7-1-26)

b. Accompanying a participant to medical appointments or other trips reasonably required for medical diagnosis or treatment. (7-1-26)

c. Shopping for food or other items specific to a participant's health and maintenance. (7-1-26)

**03. Place of Service.** PCS may be provided in a participant's personal residence, including a CFH, a RALF, or a PCS Family Alternate Care Home (FACH), and in the community only when an individual's daily activities take them out of the home and are limited to tasks in their approved service plan. (7-1-26)

**04. Service Exclusions.** (7-1-26)

a. Irrigating or suctioning any body cavity requiring sterile procedures or applying dressings with prescription medication or aseptic techniques; (7-1-26)

b. Catheter insertion or sterile irrigation; (7-1-26)

c. Injecting fluids into veins, muscles or skin; and (7-1-26)

d. Administering medication not authorized by a supervisor RN. (7-1-26)

**05. Participant Limitations.** Sixteen (16) hours per week unless authorized under EPSDT. (7-1-26)

**06. ~~Provider Limitations.~~** ~~No home, regardless of the number of providers in a home, may serve more than two (2) children authorized for eight (8) or more hours of PCS per day.~~ **Supervisor RN and QIDP.** The Department authorizes oversight activities paid per visit to conduct participant evaluations and for service plan development and authorize additional evaluations or emergency visits as needed. (7-1-26)( )

## 553. PCS: PROCEDURAL REQUIREMENTS.

**01. Service Plan.** All PCS are provided based on a documented service plan according to place of service. (7-1-26)

a. PAAs prepare the service plan with participants in their own home or a PCS FACH, based on applicable physician or authorized provider information, assessment results (including any QIDP assessments or observations), and participant provided information. Service plans must include all medical and non-medical tasks the provider performs, including amount, type, and frequency. Plans must be updated annually or based on treatment

results or significant changes in participant needs.

(7-1-26)( )

- b. CFH/RALF service plans must meet applicable licensing requirements for each residence type. (7-1-26)

02. **Supervision.** An RN or QIDP provides oversight of PCS as required by the Department. Activities include: (7-1-26)

- a. Service plan development assistance, including in-home active treatment plans. (7-1-26)

b. Review of treatment provided and verified by service delivery records and through on-site participant interviews. (7-1-26)

c. Service plan re-evaluations, including on-site visits to evaluate change in a participant's condition as needed. (7-1-26)

d. Immediate notification to any guardian, emergency contact, or family member when a significant change in a participant's physical condition or response to services occurs. (7-1-26)

03. **PA.** Authorizations are based on the participant's assessment, individual service plan, and any other medical information supporting medical needs. (7-1-26)

04. **Record Requirements in Participant Homes.** PCS records must be maintained for all participants in their own homes or in a PCS (FACH), in a format accessible to the participant. (7-1-26)

a. Providers must document every visit made to a participant's home and record the date, time, duration, services provided, and any changes noted in a participant's condition or deviations from the service plan. (7-1-26)

- b. Participants or legal guardians must verify service delivery by signing the record. (7-1-26)

c. Providers must sign the service plan indicating they will deliver services according to the authorization and consistent with HCBS requirements. (7-1-26)

d. EVV systems described do not replace documentation requirements but may be used to generate documentation. (7-1-26)

05. **Provider Notification.** Providers must notify the Department and the medical provider ~~for~~ when any significant changes in a participant's condition occur, and document in the participant record. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**555. PCS: REIMBURSEMENT.**

~~01. **Calculated Fee.** Fees include a basic rate for PCS and mileage. No separate charges are paid for provider transportation to and from a participant's home or non-medical transportation, unless authorized by the Department under another billable service. (7-1-26)~~

~~02. **Rate Methodology.** Rates are calculated using an annual survey of all Idaho NFs and ICFs/IID to establish the WAHR for Idaho NF employees in comparable positions. (7-1-26)~~

~~03. **PAA Rates.** The Department establishes PAA rates for PCS based on the WAHR multiplied by a supplemental component composed of costs reported for travel, administration, training, and all payroll taxes and fringe benefits collected during the most recent State Fiscal Year. (7-1-26)~~

**041. CFH and RALF Rates.** PCS rates for residents are paid based on their assessed care level as follows: (7-1-26)

**a.** Level I, any diagnosis EXCEPT Serious and Persistent Mental Illness (SPMI), DD, Alzheimer's Disease and Related Dementias (ADRD) = one and twenty-five hundredths (1.25) hrs/day. (7-1-26)

**b.** Level II, any diagnosis EXCEPT SPMI, DD, ADRD = one and five tenths (1.5) hrs/day. (7-1-26)

**c.** Level III, any diagnosis = two and twenty-five hundredths (2.25) hrs/day. (7-1-26)

**d.** Level IV, ONLY SPMI, DD, ADRD who scores at level one (1) or two (2) = one and seventy-nine hundredths (1.79) hrs/day. (7-1-26)

**052. Supervisor RN and QIDP Rates.** The Department authorizes oversight activities paid per visit to conduct participant evaluations and for Service Plan development and may authorize additional evaluations or emergency visits as needed. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**560. DD SERVICES: REQUIREMENTS.**

DD services, including ~~Family Directed Community Supports (FDCS)~~, are covered when provided with the right care, in the right place, at the right price, and with the right outcomes to enhance health and safety, and promote participants' rights, self-determination, and independence. Services require an assessment of the need for services, service plan development ~~of a service plan~~ with the budget assigned by the Department, PA of services, and a quality improvement program. (7-1-26)

**01. Right Care.** Standard of care for the diagnosis, functional needs, and abilities to achieve the desired outcome. (7-1-26)

**02. Right Place.** Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (7-1-26)

**03. Right Price.** The most integrated and least expensive services that are sufficient to address the participant's needs as identified in the assessment. (7-1-26)

**04. Right Outcomes.** Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (7-1-26)

**561. DD DETERMINATION STANDARDS: PARTICIPANT ELIGIBILITY.**

Assessments required for determining eligibility are completed prior to the participant receiving services and include documentation of a DD, an MSDA, and a functional assessment. For adult DD waiver services, an assessor must determine the participant meets ICF/IID level of care. DD as under Section 66-402, Idaho Code, is a chronic disability that appears before the age of twenty-two (22) years evidenced by: (7-1-26)

**01. Impairment.** Impairment is attributed to one (1) of the following: (7-1-26)

**a.** Intellectual Disability. (7-1-26)

**i.** IQ test score of seventy (70) or below with a five (5) point standard error of measurement; or (7-1-26)

**ii.** A delay of thirty percent (30%) overall on a functional assessment when under the age of five (5). (7-1-26)

**b.** Cerebral Palsy. (7-1-26)

- c. Epilepsy, except when seizure-free and not on medication for three (3) years. (7-1-26)
  - d. Autism. (7-1-26)
  - e. Other conditions closely related or similar to a-d. requiring similar treatment or services: (7-1-26)
  - i. IQ test score above seventy-five (75) when functional limitations create a condition like intellectual disability. (7-1-26)
  - ii. Disruption in motor function like cerebral palsy. (7-1-26)
  - iii. Disorder causing interruption of consciousness like epilepsy. (7-1-26)
  - iv. Not a mental illness. (7-1-26)
  - f. Dyslexia resulting from a-e. (7-1-26)
- 02. Substantial Functional Limitations.** The impairment requires a combination and sequence of services that need to be individually planned and coordinated for substantial functional limitations within three (3) major life activities in b-h. (7-1-26)
- a. Substantial functional limitations are demonstrated by having a score of two (2) standard deviations below the mean. Participants under three (3) years of age can alternatively demonstrate by: (7-1-26)(      )
    - i. Scoring thirty percent (30%) below age norm; or (7-1-26)
    - ii. Exhibiting a six (6) month delay. (7-1-26)
  - b. Self-care. (7-1-26)
    - i. Under Age twenty-one (21): Manifested when age-appropriate skills are limited, and substantial assistance is required. (7-1-26)
    - ii. Age twenty-one (21) and Over: Manifested when the person requires assistance in performing eating, hygiene, grooming, or health care skills, or the time to complete these tasks causes substantial impairment of conducting other ADL or retaining employment. (7-1-26)
  - c. Receptive and expressive language. (7-1-26)
    - i. Under Age three (3): Manifested when they have been diagnosed with performance thirty percent (30%) below age norm (adjusted for prematurity up to two (2) years) or demonstrated at least two (2) standard deviations below the mean in either area or one-and-one half (1 1/2) below in both areas of language development. (7-1-26)
    - ii. Age three (3) and Above: Manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). (7-1-26)
  - d. Learning manifested when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that interventions beyond normal are required for the development of social, self-care, language, academic, or vocational skills. (7-1-26)
  - e. Mobility. (7-1-26)
    - i. Under Age twenty-one (21): Measured by an age-appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with skills expected of children of the same age. (7-1-26)

- ii. Age twenty-one (21) and Over: Manifested when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. (7-1-26)
  - f. Self-direction. (7-1-26)
  - i. Under Age twenty-one (21): Manifested when the child is unable to help themselves or cooperate with others with age-appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments. (7-1-26)
  - ii. Age twenty-one (21) and Over: Manifested when assistance is required in managing personal finances, protecting self-interest, or making decisions that may affect well-being. (7-1-26)
  - g. Capacity for independent living. (7-1-26)
  - i. Under Age twenty-one (21): Measured by an age-appropriate instrument that compares personal independence and social responsibility expected of comparable age and cultural groups. (7-1-26)
  - ii. Age twenty-one (21) and Over: A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. (7-1-26)
  - h. Economic self-sufficiency. (7-1-26)
  - i. Under Age five (5): Evidenced by eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). (7-1-26)
  - ii. Age five (5) to Age Twenty-one (21): Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. (7-1-26)
  - iii. Age twenty-one (21) and Over: Manifested when unable to perform the tasks necessary for regular employment or limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. (7-1-26)
- 03. Necessity of Care.** The need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated. (7-1-26)
- a. Under Age five (5): Determined by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP. (7-1-26)
  - b. Age five (5) and Over: Life-long or extended duration means the condition has reasonable likelihood of continuing for a protracted period, including continuation throughout life. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**568. ADULT DD SERVICES: DEFINITIONS.**

- 01. Clinical Review.** Process of professional review to validate the need for continued services. (7-1-26)
- 02. Exception Review.** Clinical review of a plan falling outside established standards due to a health or safety risk. (7-1-26)

**03. Health.** The prevention of deterioration of one's physical or mental health condition, cognitive functioning, or an increase in maladaptive behavior, and is related to the effects of one's disability. (7-1-26)

**04. Health Risks.** Must be established through written documentation and current treatment recommendations from a ~~licensed practitioner of the healing arts under these rules, or other~~ professional licensed by the State of Idaho whose recommendation is within the scope of their license. Such documentation must establish: (7-1-26)( )

**a.** The current physical or mental condition, or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and (7-1-26)

**b.** The specific supports or services being requested, including type and frequency if applicable, that will address the identified need. (7-1-26)

**c.** To comply with the documentation requirement, the Department may require the participant to obtain additional consultation or assessment, available to the participant and covered by Medicaid, from a professional licensed by the State of Idaho acting within the scope of their license. If the Department requires additional consultation or assessment, the Department will specify the nature of the consultation or assessment and the necessary documentation. (7-1-26)

**05. Safety.** Prevention of criminal activity, destruction of property, or injury or harm to self or others. (7-1-26)

**06. Safety Risks.** Must be documented by the following: (7-1-26)

**a.** Current incident reports; (7-1-26)

**b.** Police reports; (7-1-26)

**c.** Assessments from a ~~licensed practitioner of the healing arts under these rules or a~~ professional licensed in Idaho and whose assessment is within the scope of their license; or (7-1-26)( )

**d.** Status reports and implementation plans that reflect the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s). (7-1-26)

**e.** Such documentation must establish: (7-1-26)

**i.** An imminent or likely safety risk; and (7-1-26)

**ii.** The specific supports or services that are being requested, including the type and frequency if applicable, that are likely to prevent that risk. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**571. ADULT DD SERVICES: COVERAGE AND LIMITATIONS.**

PA is required for ~~service coordination~~, DD waiver and DD state plan services. Services must be delivered under a service plan by providers selected by the participant. (7-1-26)( )

**572. ADULT DD SERVICES: PROCEDURAL REQUIREMENTS.**

Providers must immediately report all allegations, observations, or suspicions of mistreatment, abuse, neglect, or exploitation, and injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other required entity. (7-1-26)( )

**573. ADULT DD SERVICES: SERVICE PLAN REQUIREMENTS.**

The service plan identifies the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and providers. The service plan must include activities to promote progress, maintain functional skills, or delay or prevent regression. Unless the participant has a guardian, who retains full decision-making authority, the participant must make decisions regarding the type and amount of services. The Department, with the participant, ensures the service plan is based on the individualized participant budget. The plan developer must distribute a copy of the service plan, in whole or part, to any other provider identified by the participant during the person-centered planning process. (7-1-26)

**01. Assessment.** The assessment with a Department-approved tool for DD service eligibility is required for all participants prior to plan development and includes: (7-1-26)

**a.** History and Physical. A medical provider's assessment and referral for nursing services and developmental therapy if anticipated to be part of the service plan. A history and physical is required within the year prior to the initiation of service and updated annually, by the medical provider. (7-1-26)

**b.** Medical, Social, and Developmental Assessment (MSDA). An assessment reviewed annually to assure it accurately reflects the participant's status. The current assessment must be evaluated prior to the initiation of adult DD services. Providers obtain and use this assessment documentation for adult program or service plan development. (7-1-26)

**c.** Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. (7-1-26)

**d.** Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. (7-1-26)

**02. Paid Plan Developer Qualifications.** Providers of direct services to the participant, or the assessor, cannot be chosen to be a paid plan developer. Plan development requires an individual be employed as a service coordinator. (7-1-26)

**03. Plan Development.** The plan development process must meet the HCBS person-centered planning requirements. The participant may facilitate their own person-centered planning meeting or designate a paid or non-paid plan developer. (7-1-26)

**04. No Duplication of Services.** The plan developer ensures that there is no duplication of services. (7-1-26)

**05. Plan Monitoring.** The planning team, including a plan monitor, must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring includes contacting providers to identify barriers to service delivery, discussing participant satisfaction with the quality and quantity of their services, and review of provider status reviews. (7-1-26)

**06. Provider Status Reviews.** Providers required to develop a PIP must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual review is due fifteen (15) days after the end of the sixth month. The annual review is due thirty (30) days after plan's end. Semi-annual and annual reviews include status of supports and services to identify progress, maintenance, or delay or prevention of regression. (7-1-26)

**07. Informed Choice.** Prior to plan development, the plan developer must document they provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. Planning team members must each indicate whether they believe the service plan meets the needs of the participant and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the service plan or amendment may be referred to the Department to negotiate a resolution. (7-1-26)

**08. Provider Implementation Plan (PIP).** Providers must develop a PIP that complies with HCBS setting requirements and identifies specific measurable objectives that relate to goals finalized and agreed to in the participant's authorized service plan. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the service plan. (7-1-26)

- a.** Exceptions. A PIP is not required for providers of: (7-1-26)
  - i. Specialized medical equipment; (7-1-26)
  - ii. Home-delivered meals; (7-1-26)
  - iii. Environmental accessibility adaptations; (7-1-26)
  - iv. Non-Medical Transportation; (7-1-26)
  - v. Personal Emergency Response System; (7-1-26)
  - vi. Respite care; (7-1-26)
  - vii. Chore services; (7-1-26)
  - viii. Community crisis support services; ~~and~~ (7-1-26)( )
  - ~~ix. Adult DD service coordination; and~~ (7-1-26)
  - ~~ix.~~ Adult Day Health. (7-1-26)

**b.** Time To Complete. PIPs must be completed within fourteen (14) days of receipt of the authorized service plan, or the service start date, whichever is later. If the authorized service plan is received after the service start date, providers must support billing by documenting service delivery as agreed to by the participant and consistent with these rules. PIP revisions must be based on changes to the needs of the participant. (7-1-26)

**c.** PIP changes must be included in the participant's record, stating the reason for the change, documentation of coordination with other providers, the date a change was made, and the name and title of the person making the change. (7-1-26)

**09. Addendum to the Service Plan.** (7-1-26)

**a.** A service plan may be adjusted during the year with an addendum, subject to Department PA. These adjustments must be based on a change to a cost, addition or increase of a service, change of provider, addition of a restrictive intervention, or addition or increase of alone time. Additional assessments or information may be clinically necessary. (7-1-26)

**b.** The Department distributes a copy of the authorized addendum to providers responsible for the implementation of the plan. (7-1-26)

**c.** Upon receipt of the addendum, the provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision with their title and the date signed and maintained in the participant's record. Provider signatures are completed each time an addendum is authorized. (7-1-26)

**10. Annual Service Reauthorization.** A new service plan must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current service plan for personal assistance unless delayed because of participant unavailability due to extenuating circumstances. If the service plan is not submitted within the period, authorization for provider payments may be terminated. Prior to submission, the plan developer must notify the providers who appear on the service plan of the annual review date, obtain a copy of the most recent provider status review, and convene the person-centered planning team to develop a new service plan.

(7-1-26)

11. **Notifications.** The Department notifies participants of its decision on their service plan. Notification includes an individualized explanation and how to appeal. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**581. CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.**

Eligibility also applies to Family Directed Community Supports (FDCS). (7-1-26)

~~01. Eligibility Determination.~~ A participant is eligible for the children's DD HCBS state plan option and FDCS from birth through age seventeen (17), when they have a DD and a demonstrated need for these services. A participant who meets Level II criteria or higher qualifies for ICF/IID Level of Care eligibility. (7-1-26)( )

~~021. Individualized Budget Methodology.~~ ~~The following categories are used to determine individualized budgets for children with DD:~~ Criteria as determined by a Department-approved tool. (7-1-26)( )

a. Level I. ~~Children m~~Meeting DD criteria. (7-1-26)( )

b. Level II. ~~Children who qualify based on f~~Functional limitations when their composite full-scale standard score of less than ~~fifty sixty~~ (560) or ~~have an the~~ overall standard score up to ~~fifty sixty~~-three (563) when combined with a maladaptive behavior score of ~~greater than one (1) to less than two (2) standard deviations from the mean nineteen (19) or twenty (20).~~ (7-1-26)( )

c. Level III. ~~Children who qualify based on f~~Functional limitations with a composite full-scale standard score less than ~~fifty sixty~~ (560) ~~with and~~ an autism spectrum disorder diagnosis. (7-1-26)( )

d. Level IV. ~~Children who qualify based on m~~Maladaptive behaviors ~~when their maladaptive behavior v-Scale score is two (2) standard deviations or greater from the mean twenty-one (21) or greater, or if on the Behavioral Category the participant scores a two (2) on critical items or two (2) or more critical items score as a one (1).~~ (7-1-26)( )

03. **Annual Re-Evaluation.** Budgets are re-evaluated annually or at the request of the participant; ~~or the Department,~~ when there are documented changes that may support placement in a different budget category. (7-1-26)( )

04. **Lapse in Service.** For participants re-applying for services, the assessor evaluates whether assessments are current and accurately describe the status of the participant. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**602. DEVELOPMENTAL THERAPY: COVERAGE AND LIMITATIONS.**

01. **Coverage.** Developmental therapy is delivered in a DDA center-based program, the community, or the participant's home, and includes individual developmental therapy and group developmental therapy. Services must: (7-1-26)

a. Be directed toward rehabilitation or habilitation of physical or DDs in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. (7-1-26)

b. Include age-appropriate instruction in ADLs not gained by a participant during normal developmental stages or not likely to develop without training or therapy. (7-1-26)

~~e. Not include tutorial activities or assistance with educational tasks associated with educational needs resulting from a disability. (7-1-26)~~

~~dc.~~ Both individual and group therapy must be available based on participant needs, interests, or choices. (7-1-26)

~~ed.~~ Include a minimum of one (1) qualified staff member providing direct services for every twelve (12) participants when center based. (7-1-26)

~~fe.~~ Occur in integrated, inclusive settings with no more than three (3) participants per qualified staff at each community-based session. Additional staff must be added when necessary to meet the needs of each individual served. (7-1-26)

**02. Limitations.** Developmental therapy may not exceed these limitations: (7-1-26)

**a.** No more than twenty-two (22) hours per week. (7-1-26)

**b.** No more than forty (40) hours per week in combination with ADH and supported employment. (7-1-26)

**c.** Only one (1) type of Medicaid-reimbursable therapy during a single period. (7-1-26)

**d.** Cannot be reimbursed when providing transportation to and from the agency. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**604. ~~DEVELOPMENTAL THERAPY: INDIVIDUAL PROGRAM PLAN (IPP) PROCEDURAL REQUIREMENTS.~~(RESERVED)**

~~**01. Intake.** Participants receiving HCBS A&D waiver services or PCS only requesting Developmental Therapy, may access services using an IPP, which does not require a DD plan developer. Services delivered through an IPP must be authorized by the Department and be based on the A&D waiver Service Plan. Prior to service delivery, a DDA must complete an IPP that meets the standards below. (7-1-26)~~

~~**02. IPP Development.** IPPs must: (7-1-26)~~

~~**a.** Be developed after completion of all required assessments; (7-1-26)~~

~~**b.** Be signed prior to delivery of services by a medical provider, the participant, and their legal guardian if applicable; (7-1-26)~~

~~**c.** Be developed at least annually, or more often, when necessary, to review or update the IPP to reflect any changes in the participant's needs or status; and (7-1-26)~~

~~**d.** Promote self-sufficiency, participant choice in program objectives and activities, encourage participant's participation and inclusion in the community, and contain age-appropriate objectives. (7-1-26)~~

~~**03. IPP Changes.** Changes to an IPP require notification and written authorization by the participant and their legal guardian if one (1) exists. Changes in type, amount, or duration of services must be recommended by a medical provider in writing. If the signatures of the participant or their legal guardian cannot be obtained, the DDA must document in the participant's record why signatures were not obtained. IPP changes must include the following documentation in the participant's record: (7-1-26)~~

~~**a.** Reason for a change; (7-1-26)~~

- ~~b.~~ Coordination with other service providers, when applicable; (7-1-26)
- ~~c.~~ Date of change; and (7-1-26)
- ~~d.~~ Signature, date, credentials, and title of the professional making the change. (7-1-26)

**605. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.**

DDAs must obtain all assessments required for DD services eligibility, billing no more than four (4) hours for the combination of all assessment, evaluation, or diagnostic services provided in a ~~calendar~~ plan year. The following assessment and diagnostic services are reimbursable: (7-1-26)(    )

**01. Comprehensive Developmental Assessment.** Assessments must: (7-1-26)

**a.** Be conducted by a Developmental Specialist and determine necessity of a service, guide treatment, and identify the participant's current strengths, needs, and interests. (7-1-26)

**b.** Be signed and dated by the professional completing the assessment, including their appropriate professional credentials or qualifications. (7-1-26)

**c.** Reflect the current status of the participant with assessments completed or updated at least every two (2) years. (7-1-26)

**d.** Reflect a person's developmental status in the following areas: (7-1-26)

i. Self-care; (7-1-26)

ii. Receptive and expressive language; (7-1-26)

iii. Learning; (7-1-26)

iv. Gross and fine motor development; (7-1-26)

v. Self-direction; (7-1-26)

vi. Capacity for independent living; and (7-1-26)

vii. Economic self-sufficiency. (7-1-26)

**02. Specific Skill Assessments.** These assessments must: (7-1-26)

**a.** Further assess an area of limitation or deficit identified on a comprehensive developmental assessment. (7-1-26)

**b.** Relate to a goal on an ~~IPP~~ or ISP. (7-1-26)(    )

**c.** Be conducted by qualified professionals to determine a participant's skill level within an area. (7-1-26)

**d.** Be used to determine baselines and develop a PIP. (7-1-26)

**03. Documentation Requirements.** DDAs must maintain records for each participant served. Each record must include documentation of the participant's involvement in and response to the services provided. For each participant, the following documentation is required: (7-1-26)

**a.** Daily entry of all activities conducted toward meeting their objectives. (7-1-26)

- b. Sufficient progress data accurately assessing a participant's progress toward each objective; (7-1-26)
- c. Review of data, and, when applicable, changes in the daily activities or implementation procedures by the qualified professional, including their dated initials. (7-1-26)
- d. Documentation for six (6) month and annual reviews by the Developmental Specialist including a written description of the participant's progress toward their achievement of therapeutic goals, and reasons they continue to need services. (7-1-26)
- e. Authorized service plan. (7-1-26)

**04. PIP Requirements.** The DDA must develop a PIP for each DDA objective included on the participant's ~~IPP or~~ ISP. All PIPs must relate to a goal or objective on the participant's ~~IPP or~~ ISP. PIPs must be developed within fourteen (14) days of service start date or receipt of an authorized ~~IPP or~~ ISP and be revised whenever participant needs change. If the PIP is not completed within fourteen (14) days, the participant's records must contain participant-based documentation justifying the delay. The provider addresses goals and objectives as agreed to by the participant until the annual PIP is completed and documents service delivery related to their interim goals and objectives. The PIP must include: (7-1-26)(      )

- a. Participant's name. (7-1-26)
- b. A baseline statement addressing the participant's skill level and abilities related to specific skills to be learned. (7-1-26)
- c. Measurable, behaviorally stated objectives corresponding to the goals or objectives authorized in the service plan. (7-1-26)
- d. Written instructions for staff that 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 stated objectives. (7-1-26)
- e. Identification of the environments where services are provided. (7-1-26)
- f. Target date for completion. (7-1-26)

**05. Informed Objectives.** Results from a psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided by the DDA accommodate the participant's mental health needs and none of the therapeutic methods are contra-indicated or delivered in a manner that presents risks to the participant's mental health status. (7-1-26)

**606. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.**

**01. Developmental Specialists.** Developmental Specialists for adults must have two hundred forty (240) hours of professionally supervised experience with individuals with DD and either: (7-1-26)

- a. Possess a bachelor's or master's degree in the human services field; or (7-1-26)
- b. Possess a bachelor's or master's degree in any area and have: (7-1-26)

  - i. Completed a competency course approved by the Department relating to Developmental Specialist job requirements; and (7-1-26)
  - ii. Passed a Department-approved competency examination. (7-1-26)
- c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless

previously disallowed by the Department, may continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (7-1-26)

**02. Developmental Therapy Paraprofessionals.** Paraprofessionals who are at least seventeen (17) years old may be used by a DDA to provide developmental therapy when under the supervision of a Developmental Specialist. (7-1-26)

**03. Collaboration with Other Providers.** When participants receive rehabilitative or habilitative services from other providers, the DDA must coordinate each participant's program with their providers to maximize skill acquisition and generalization of skills across environments and avoid duplication of services. DDAs must maintain documentation of any collaboration that includes other service plans. Participant's files must also reflect how all services are integrated into a DDA's plan for each participant. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**611. ADULT DD WAIVER SERVICES: PARTICIPANT ELIGIBILITY.**

The Department determines waiver eligibility. The participant must meet the following: (7-1-26)

**01. Age.** Be eighteen (18) years or older. (7-1-26)

**02. Eligibility.** The Department must determine whether: (7-1-26)

**a.** The participant would qualify for ICF/IID level of care if the DD waiver services were not available; (7-1-26)

**b.** The participant can reside safely and effectively in a non-institutional setting; and (7-1-26)

**c.** The average annual cost of a participant's waiver and other medical services do not exceed the average annual cost to Medicaid for ICF/IID care and other medical costs. (7-1-26)

**03. DD Waiver Eligibility.** Participants eligible for DD waiver services may instead choose admission to an ICF/IID. (7-1-26)

**04. Redetermination.** (7-1-26)

**a.** Financial and medical redetermination are conducted annually or sooner at the request of the participant, self-reliance, a provider agency, or medical provider. (7-1-26)

**b.** The redetermination process will assess the participant's continued need and eligibility for waiver services and discharge from the waiver services program. (7-1-26)

**05. Notifications.** The Department notifies participants of the eligibility decision after an assessment. Notification includes an individualized explanation of the decision and how they may appeal. (7-1-26)

**06. Adult DD Waiver Limits.** The number of Medicaid participants to receive waiver services under the Adult DD waiver is limited to the projected number of users in a CMS-approved waiver. Individuals applying for this waiver after the maximum is reached are placed on a waiting list to have their applications processed after September 30th for the first date of a new DD waiver year. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**614. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.**

- 01. Residential Habilitation – Supported Living.** Employment by a licensed residential habilitation agency. Direct care staff must: (7-1-26)
- a.** Be at least eighteen (18) years old; (7-1-26)
  - b.** Be free from communicable disease; (7-1-26)
  - c.** Demonstrate the ability to administer the plan of service; (7-1-26)
  - d.** Have a valid driver's license and vehicle insurance, if transporting participants; (7-1-26)
  - e.** Receive training by a QIDP who has demonstrated experience in writing skill training programs. Training programs must include an orientation program completed before providing services, and additional ongoing training during employment. (7-1-26)
- 02. Residential Habilitation – CFH.** Individuals providing direct services in their own home must be a CFH, receive program coordination provided through the Department, and: (7-1-26)
- a.** Be free from communicable disease; (7-1-26)
  - b.** Have a valid driver's license and vehicle insurance, if transporting participants; and (7-1-26)
  - c.** Have certification or licensure to perform tasks requiring certification or licensure. (7-1-26)
  - d.** Prior to delivering services to a participant, complete an orientation training provided by the Department and additional training requirements for CFH providers within six (6) months of certification date. (7-1-26)
- 03. Chore Services.** Be skilled in the service to be provided and demonstrate the ability to follow a service plan. (7-1-26)
- 04. Respite Care.** Receive instructions in the participant's needs, demonstrate the ability to follow a service plan, and be free of communicable disease. (7-1-26)
- 05. Supported Employment.** Provided by an agency accredited by CARF or meet State requirements to be an agency. (7-1-26)
- 06. Non-Medical Transportation.** Possess a valid driver's license and vehicle insurance. (7-1-26)
- 07. Specialized Medical Equipment.** Enrollment as a supplier and ensure all items meet applicable standards of manufacture, design, and installation. Preference is given to the most cost-effective option to meet the participant's needs. (7-1-26)
- 08. PERS.** Demonstration that the devices installed in a participant's home meet FCC standards. (7-1-26)
- 09. Home-Delivered Meals.** Provided by a public agency or business ensuring: (7-1-26)
- a.** Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the USDA; (7-1-26)
  - b.** Meals are delivered in a sanitary manner, and at the correct temperature for the specific type of food; and (7-1-26)
  - c.** A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions. (7-1-26)

- 10. Behavior Consultation or Crisis Management.** (7-1-26)
- a.** Work under the direct supervision of a psychologist or PhD in Special Education with training and experience treating severe behavior problems and applied behavior analysis; and (7-1-26)
- i.** Have a Master's degree in a behavioral science or a closely related field; (7-1-26)
- ii.** Be a licensed pharmacist; or (7-1-26)
- iii.** Be a QIDP. (7-1-26)
- b.** Emergency back-up providers must meet the qualifications of a residential habilitation agency. (7-1-26)
- 11. Adult Day Health.** (7-1-26)
- a.** Services provided in a facility must meet the building and health standards ~~under IDAPA 16.03.21~~ of a DDA; (7-1-26)( )
- b.** Provide care and supervision appropriate to the participant's needs as identified on the plan. (7-1-26)
- c.** Free from communicable disease. (7-1-26)
- 12. Transition Services.** Transition managers. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**630. SERVICE COORDINATION: DEFINITIONS.**

~~**01. Conflict of Interest.** A situation in which an agency or person directly or indirectly influences, or appears to influence, the direction of a participant to other services for financial gain. (7-1-26)~~

~~**02.**~~ **021. Crisis.** An unanticipated event, circumstance, or life situation placing a participant at risk of hospitalization, loss of housing, loss of employment or major source of income, incarceration, or physical harm to self or others, including family altercation or psychiatric relapse. (7-1-26)

**631. SERVICE COORDINATION: PARTICIPANT ELIGIBILITY.**

**01. Adults.** A DD diagnosis and a need for assistance to access services and supports necessary to maintain their independence. (7-1-26)( )

**02. Children.** All information necessary to make an eligibility determination must be received by the Department twenty (20) business days prior to the anticipated service coordination start date. The Department determines eligibility based on information provided by the service coordination agency or the family prior to the initiation of initial and ongoing plan development and services. Participants must meet the following requirements: (7-1-26)

- a.** Age of thirty-seven (37) months through the month of their 21st birthday. (7-1-26)
- b.** A diagnosis with special health care needs requiring medical and multidisciplinary rehabilitation services identified by a medical provider to prevent or minimize disability. (7-1-26)
- c.** Reimbursement for services is not available for participants whose needs can be met by other paid or unpaid sources. The child must require service coordination for one (1) or more of the following: (7-1-26)

- i. A condition resulting in functioning below normal age level in one (1) or more life areas; (7-1-26)
- ii. At risk of placement in a more restrictive environment or returning a child from an out of home placement due to their condition; (7-1-26)
- iii. Danger to the health or safety of the child exists or a parent is unable to meet the child's needs; (7-1-26)
- iv. Further complications may occur due to the condition without service coordination; or (7-1-26)
- v. Requires multiple service providers and treatments. (7-1-26)

**632. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.**

The Department covers service coordination for individuals who are unable, or have limited ability to gain access, coordinate, or maintain services on their own or through other means. These rules are not applicable to case management services provided under the A&D waiver, Transition Management benefit, or under managed care contracts. Service coordination includes: (7-1-26)( )

**01. Plan Assessment and Reassessment.** Activities required when determining participant needs during plan development and reassessment that include completing documentation related to a participant's history, identifying a participant's needs, and gathering information to form a complete assessment of the participant. (7-1-26)

**02. Plan Development.** Development and revision of a service coordination plan including information collected through the assessment and specifying goals and actions needed by the participant. Plans must be updated annually or as needed to meet participant needs. (7-1-26)

**03. Monitoring and Follow-Up.** Contacts necessary to ensure a plan is implemented and adequately addresses a participant's needs and conducted as frequently as necessary. Activities must include one (1) or more face-to-face contacts with a participant at least every ninety (90) days and may occur via synchronous virtual care to determine: (7-1-26)

- a. Services are provided according to the plan; (7-1-26)
- b. Services in the plan are adequate; and (7-1-26)
- c. Whether there are changes in the needs or status of a participant, requiring adjustments to the plan or service arrangements with providers. (7-1-26)

**04. Crisis Assistance.** Coordination used to help a participant access community resources to resolve a crisis that does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. (7-1-26)

a. Crisis Assistance hours are unavailable until all available hours of service coordination have already been provided in the month. (7-1-26)

b. Authorization for crisis assistance is requested retroactively due to a crisis when a participant's service coordination benefits are exhausted, and no other support is available. A service coordinator must complete a crisis resolution plan and submit a request for crisis services to the Department within five (5) business days of the last day of providing the service. (7-1-26)

**05. Contacts.** Service coordination may include contacts with non-eligible individuals only when a contact directly relates to identifying the needs and supports to help a participant access services. (7-1-26)

**06. Exclusions.** Service coordination does not include activities that are integral components of another covered service, integral to administration of foster care programs, or integral to administration of another

program a participant is eligible for, except case management required by IDEA. (7-1-26)

**07. Limitations.** (7-1-26)

**a.** Providers may only deliver service coordination and direct services to the same Medicaid participant when they receive children's services coordination. (7-1-26)( )

**b.** Service coordination cannot exceed four point five (4.5) hours per month, unless when accessing unused hours in an individual's current plan from previous months. (7-1-26)( )

**c.** Reimbursement for annual assessment and plan development cannot exceed twelve (12) hours per year. (7-1-26)

**d.** Participants receiving hospice services or who live in hospitals, NFs, or ICF/IIDs are not eligible for service coordination. (7-1-26)

**e.** Participants are only eligible for one (1) type of service coordination. Participants who qualify for more than one (1) type, must choose one (1) that best meets their needs. (7-1-26)

**f.** Group services are not reimbursable. (7-1-26)

**g.** Missed appointments, attempted contacts, travel to provide services, leaving messages, scheduling appointments with a Medicaid-enrolled service coordinator, transporting participants, or documenting services are not reimbursable. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**634. SERVICE COORDINATION: PROVIDER QUALIFICATIONS AND DUTIES.**

**01. Provider Agreement.** Providers must be employees or contractors of an agency. (7-1-26)

**02. Supervision.** Agencies must provide supervision to all providers by clearly documenting each supervisor's ability to address concerns about the services provided under their supervision. (7-1-26)

**03. Supervisor Requirements.** (7-1-26)

**a.** Master's Degree in a human services field, and twelve (12) months supervised work experience with the population served; or (7-1-26)

**b.** Bachelor's degree in a human services field or RN, and twenty-four (24) months of supervised work experience with the population served. (7-1-26)( )

**04. Service Coordinator Requirements.** (7-1-26)

**a.** Bachelor's degree in a human services field or RN and twelve (12) months of supervised work experience with the population served. (7-1-26)( )

**b.** Individuals meeting education or licensing requirements but without the required supervised work experience must be supervised by a qualified service coordinator while gaining the required work experience. (7-1-26)

**05. Paraprofessional Requirements.** Under the supervision of a qualified service coordinator, a paraprofessional can assist in the implementation of the plan. Paraprofessionals cannot conduct assessments, evaluations, person-centered planning meetings, 90-day face-to-face contacts, 180-day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as a service coordinator on the plan and cannot

supervise service coordinators or other paraprofessionals. They must: (7-1-26)

a. Be eighteen (18) years or older with a high school diploma or equivalency and twelve (12) months supervised work experience with the population served; and (7-1-26)

b. Be able to read and write at a level necessary to process all paperwork and forms required for service delivery. (7-1-26)

06. **Health, Safety, and Fraud Reporting.** Providers must report any concerns about fraud, health, and safety to the appropriate governing agency and the Department. (7-1-26)

07. **Case Loads.** The total caseload of a provider must assure quality service delivery and participant satisfaction. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**800. PARTICIPANT ELIGIBILITY.**

01. **Eligibility Determination.** ~~In order to choose the CDCS option, the participant must first be determined Medicaid-eligible and determined to meet existing Adult DD waiver or Children's HCBS State Plan Option requirements~~ to choose the CDCS option. (7-1-26)( )

02. **Participant Agreement.** The participant, if able, and their legal representative, if ~~one exists applicable~~, must agree ~~in writing using a Department approved form~~ to the following using a Department-approved form: (7-1-26)( )

a. ~~Accept~~ The following CDCS guiding principles for the CDCS option; (7-1-26)( )

i. Freedom for the participant to make choices and plan their own life; (7-1-26)

ii. Authority for the participant to control resources allocated to them to acquire needed supports; (7-1-26)

iii. Opportunity for the participant to choose their own supports; (7-1-26)

iv. Responsibility for the participant to make choices and take responsibility for the result of those choices; and (7-1-26)

v. Shared responsibility between the participant and their community to help the participant become an involved and contributing member of that community. (7-1-26)

b. ~~Agree to meet the participant responsibilities outlined in these rules;~~ (7-1-26)( )

c. ~~Take responsibility for and~~ To accept responsibility, potential risks, and any ~~resulting~~ consequences; for their support choices. ~~If the participant is unable to give consent, this falls to their legal representative; and~~ (7-1-26)( )

d. ~~Acknowledge and follow the~~ applicable HCBS rules. (7-1-26)( )

03. **Involuntary Removal.** ~~Participants involuntarily removed from the CDCS option will be ineligible for this option for a period of five (5) years. Re application will be reviewed on a case by case basis and will include consideration of the previous conditions for removal.~~ (7-1-26)

**801. PARTICIPANT RESPONSIBILITIES.**

With the assistance of the SB, and the legal representative, if ~~one exists applicable~~, the participant is responsible for

the following:

(7-1-26)( )

01. **Guiding Principles.** Accepting and honoring the guiding principles for the CDCS ~~option defined in the participant agreement.~~ (7-1-26)( )

02. **Person-Centered Planning.** Directing the person-centered planning process ~~in order~~ to identify and document paid and unpaid support and service needs, wants, and preferences. (7-1-26)( )

03. **Rates.** Negotiating ~~payment~~ rates for all ~~paid~~ community supports ~~they the participant~~ wants to purchase. ~~They must also ensure rates are~~ Negotiated rates for supports and services ~~do must~~ not exceed the prevailing market rate, are be cost-effective ~~when comparing them compared~~ to reasonable alternatives, and ~~include the details be detailed~~ in the employment agreements. (7-1-26)( )

04. **Employment Agreements.** Completing and implementing agreements for the FEA, the SB, and CSWs, and submitting the agreements to the FEA. ~~These a~~ Agreements must: ( )

a. ~~b~~ Be submitted on Department-approved forms ~~and must specifically~~ identifying the type of support being purchased, the rate negotiated ~~for the support~~, and the frequency and duration ~~of the scheduled support or service.~~ ( )

b. ~~The participant is responsible for ensuring that each employment agreement;~~ c Clearly identifies ~~identify~~ the qualifications ~~needed to provide the for a~~ support or services; includes with a statement signed by the hired worker employee and participant that they employee possesses es the needed skills; ~~and the signature of the participant that verifies the same.~~ ( )

c. ~~Additionally, each employment agreement will include s~~ Statements ~~that;~~ the participant is the employer ~~even though payment comes from a third party; employees are under the direction and control of the participant; services must be delivered consistent with the HCBS rules and manager~~ and no employer-related claims will be filed against the Department; (7-1-26)( )

d. Assure services are delivered consistent with HCBS rules; ( )

e. Ensure documentation and workbook requirements are met; ( )

f. Include providing copies of plan and plan documents to service providers; ( )

g. Require updating and submitting the workbook to the Department with the annual plan; and ( )

h. Assure duties are provided in a respectful manner. ( )

05. **SSP.** Developing a comprehensive SSP, based on the information gathered during person-centered planning. (7-1-26)

06. **Time Sheets and Invoices.** ~~Reviewing and v~~ Verifying that goods and services ~~being~~ billed were provided and indicating ~~that they approve of the bill~~ approval by signing the time sheet or invoice. (7-1-26)( )

07. **Quality Assurance and Improvement.** Providing feedback ~~to the best of their ability regarding of~~ their satisfaction with ~~the goods and services they receive and the performance of their and~~ workers. (7-1-26)( )

08. **Sufficient Staffing.** Hiring enough CSWs to ensure ~~services are rendered in a manner for the~~ health and safety ~~of the participant.~~ (7-1-26)( )

09. **Required Classes.** ~~The participant must attend classes on~~ Guide Training ~~by the Department and~~ FEA Training. (7-1-26)( )

802. CONTINUATION OF ~~THE CONSUMER DIRECTED COMMUNITY SUPPORTS (CDCS)~~ OPTION.

These ~~following~~ requirements must be met or the ~~Department may require the~~ participant ~~to discontinue~~ may be removed from the CDCS option: (7-1-26)( )

01. **Required Supports.** The participant ~~is willing to~~ must work with a/an: ( )

a. SB; and (7-1-26)( )

ab. ~~The participant can only change FEA services by providing a written request~~ can only be changed at the end of a fiscal quarter. Notice must be given in writing to their current FEA provider ~~at least~~ sixty (60) days in advance, ~~and this change must occur at the end of a fiscal quarter. The request must include~~ with the name of the new FEA ~~chosen by the participant and provide~~ the specific date of the change ~~will occur~~. (7-1-26)

b. ~~When a participant provides a written request to their current FEA provider to change to a different FEA provider, the~~ current FEA provider must notify the participant of the ~~specific date that~~ the last payroll will run ~~will occur at the end of the fiscal quarter~~. (7-1-26)( )

02. **Adherence to the Participant's SSP.** ~~The participant's SSP is followed.~~ (7-1-26)( )

03. **Adherence to Risk and Safety Back-Up Plans.** ~~Back-up plans to manage risks and safety are followed.~~ (7-1-26)( )

04. **Health and Safety Choices.** The participant's choices ~~do not~~ cannot directly endanger their health, welfare, and safety or endanger or harm others. (7-1-26)( )

**05. Involuntary Removal.** Participants involuntarily removed will be ineligible for CDCS for a period of five (5) years. Re-application will be reviewed on a case-by-case basis. ( )

**803. CIRCLE OF SUPPORTS (COS).**

The COS is unpaid, selected by the participant, and may include family members, friends, neighbors, co-workers, and other community members. When the participant's legal guardian is selected as a CSW under SDCS, the COS must include one (1) non-family member other than the SB. A family member is anyone related by blood or marriage. ( )

**031. Selection** ~~and Duties~~. Members are selected by the participant ~~and commit to work within the group to:~~ (7-1-26)( )

a. ~~Promote and improve the life of the participant in accordance with the participant's choices and preferences; and~~ (7-1-26)

b. ~~Meet regularly to assist the participant to accomplish their expressed goals.~~ (7-1-26)

**042. Focus Duties.** ~~The participant's COS is built and operates with the primary goal of working~~ meets regularly and works in the interest of the participant to promote and improve their life in accordance with their choices and preferences. The ~~group's role is to~~ COS gives and gets support for the participant and ~~to~~ develops an SSP, ~~along with and on behalf of~~ the participant; to help ~~the participant~~ accomplish their ~~personal~~ participant's goals. (7-1-26)( )

**02. Members.** A COS is unpaid, selected by the participant, and may include family members, friends, neighbors, co-workers, and other community members. ~~For the SDCS, when the participant's legal guardian is selected as a CSW, the COS must include at least one (1) non family member who is not the SB. For the purposes of this chapter a family member is anyone related by blood or marriage to the participant or legal guardian.~~ (7-1-26)

**043. Natural Supports.** Natural supports may perform any duty of the SB ~~as long as the SB still completes the except~~ required ~~responsibilities listed in these rules~~ duties. Additionally, A qualified natural support may complete any CSW task ~~may be performed by a qualified natural support person. Supports provided by a natural support person must be~~ it is identified on the participant's SSP, but time worked does not need to be recorded or reported to the FEA. (7-1-26)( )

804. (RESERVED)

805. ~~PAID CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).~~

Participants must purchase FMS and SB services to participate in ~~the CDCS option~~. Participants must purchase goods and community supports through ~~an~~ the FEA who is providing ~~the~~ FMS. All providers of CDCS must comply with the Idaho Medicaid Provider Handbook. (7-1-26)( )

01. ~~FMS. The Department will enter into a provider agreement with a~~ Qualified FEAs, ~~as defined in these rules, to~~ may be provide rs of FMS for payroll and reporting functions ~~to~~ for participants ~~who choose the on~~ CDCS ~~option~~. (7-1-26)( )

02. ~~SB Services. Services provided by a~~ A qualified SB ~~to~~ assists the participant in making informed choices, participate ing in a person-centered planning process, and become ing skilled at managing their own supports, ~~such as including~~ negotiating and budgeting. ~~SBs have to apply for requalification annually.~~ (7-1-26)( )

03. ~~CSW Services. The CSWs provide identified supports to the participant. If the identified support requires specific licensing or certification within the state of Idaho, the identified CSW must obtain the applicable license or certification they are qualified for.~~ Identified supports include activities that address the participant's preference in ~~both FDSCS and SCDCS~~, unless otherwise specified, for: (7-1-26)( )

a. Job support for SDSCS to help the participant secure, ~~and~~ maintain, or advance employment ~~or attain~~ job advancement; (7-1-26)( )

b. Personal support to ~~help the participant~~ maintain health, safety, and basic quality of life; (7-1-26)( )

c. Relationship support to ~~help the participant~~ establish and maintain positive relationships ~~with immediate family members, friends, spouse, or others in order~~ to build a natural support network and community; (7-1-26)( )

d. Emotional support to ~~help the participant~~ learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors; (7-1-26)( )

e. Learning support for SDSCS to ~~help the participant~~ learn ~~new skills~~ or improve ~~existing~~ skills that relate to ~~their~~ identified goals; (7-1-26)( )

f. Transportation ~~support~~ to help the participant accomplish their identified goals; and (7-1-26)( )

g. Skilled nursing ~~support for SDSCS~~ identified in the participant's plan ~~that is within the scope of the Nurse Practice Act and is~~ provided by an licensed registered nurse (RN), or licensed practical nurse (by an LPN) under the supervision of an RN for SDSCS, ~~licensed to practice in Idaho.~~ (7-1-26)( )

04. ~~Medically Necessary~~ Adaptive and Therapeutic Equipment. ~~Adaptive and therapeutic e~~Equipment ~~is medically necessary, meets a medical or accessibility need, and promotes increased independence. FDSCS may substitute medical necessity for minimizing the participant's need for institutionalization that meets HCBS requirements.~~ Items may be covered when: (7-1-26)( )

a. Not available through another source; (7-1-26)

b. Identified in the participant's plan; (7-1-26)

c. Recommended by the provider overseeing care; ( )

~~d.~~ Safe and effective ~~treatment that meets~~ evidence-based treatment ~~criteria~~; (7-1-26)( )

~~e.~~ Optimal for the participant's health, safety and welfare; (7-1-26)

- ~~ef.~~ Least costly alternative that reasonably meets the ~~identified~~ assessed need; ~~and~~ (7-1-26)( )
- ~~fg.~~ For the sole benefit of the participant; ~~and~~. (7-1-26)( )
- ~~g.~~ Meets at least one (1) of the following: (7-1-26)
- ~~i.~~ Assist the ability of the participant to remain in the community; (7-1-26)
- ~~ii.~~ Enhance community inclusion and family involvement; and (7-1-26)
- ~~iii.~~ Decrease dependency on formal support services. (7-1-26)
05. **Limitations.** Purchased items and Sservices have the following limitations: (7-1-26)( )
- ~~a.~~ CDCS ~~Purchased items and services m~~Must meet an assessed needs ~~related to a developmental disability diagnosis. The use of CDCS and FDCS purchased items.~~ ( )
- ~~b.~~ Cannot be used by an individual other than the participant ~~is prohibited. The following types of items or services are not covered; or for another's convenience.~~ (7-1-26)( )
- ~~i.~~ ~~For the convenience of a caregiver;~~ (7-1-26)
- ~~ii.~~ Educational; (7-1-26)
- ~~iii.~~ Recreational; ~~or~~ (7-1-26)
- ~~iv.~~ ~~Cannot be V~~vocational ~~except unless~~ pre-vocational ~~and or~~ job supports. (7-1-26)( )
- ~~bd.~~ CDCS ~~s~~Services may only be rendered by (1) staff to one (1) participant at a time. Staff may not: (7-1-26)( )
- i. Render any other support, service, or supervision, paid or unpaid, to any other individual; or (7-1-26)
- ii. Perform multiple services concurrently. (7-1-26)
- ~~ee.~~ CDCS ~~and FDCS t~~Transportation ~~support~~ is limited to one thousand eight hundred (1,800) miles annually, unless otherwise authorized. (7-1-26)( )

**(BREAK IN CONTINUITY OF SECTIONS)**

**810. ~~SUPPORT BROKER (SB)~~ REQUIREMENTS AND LIMITATIONS.**

01. **SB Requirements.** ~~Individuals interested in becoming an SB must:~~ (7-1-26)( )
- a. ~~Be e~~Eighteen (18) years of age or older; (7-1-26)( )
- ~~b.~~ Cannot be the participant's spouse, payee, conservator, or parent; ( )
- ~~bc.~~ Have sSkills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; ~~and~~ (7-1-26)( )
- ~~d.~~ Knowledge of services and resources in the DD fields; ( )

- ~~ee.~~ Have at least ~~two~~ (2) years verifiable experience with the target population; ~~and~~ (7-1-26)( )
- ~~f.~~ SBs apply for requalification annually and submit requalification applications forty-five (45) days before current qualification expires; ~~and~~ ( )
- ~~dg.~~ Knowledge of services and resources in the developmental disabilities field ~~Perform duties in a respectful manner.~~ (7-1-26)( )

02. **Application Exam.** Applicants ~~that~~ meeting the minimum requirements under this rule will receive training materials and resources to prepare for the application exam. Under FDACS, ~~children's~~ SBs must attend an initial training. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third ~~time failure, the~~ an applicant ~~will not be allowed to~~ can retest for twelve (12) months from ~~the date of~~ the last exam. Applicants who pass ~~the exam, and meet all other requirements under these rules, will be eligible to~~ can enter into a Medicaid Support Broker Agreement ~~with the Department.~~ (7-1-26)( )

03. **~~Required Ongoing~~ Continuing Training.** All SBs must document ~~a minimum of~~ twelve (12) hours per year of ongoing, relevant training in ~~the provision of~~ SB services. ~~Up to six~~ (6) hours may be ~~obtained through~~ independent self-study ~~with. The remaining hours must consist of remainder completed in a classroom training setting.~~ (7-1-26)( )

04. **Termination.** Terminated SBs are ineligible to provide services for five (5) years. Re-applications will be reviewed on a case-by-case basis. The Department may terminate the Medicaid Support Broker Agreement in accordance with Section 56-209h(6), Idaho Code, or when the SB: (7-1-26)( )

- a. ~~Is no longer able to~~ Cannot pass a background check under these rules. (7-1-26)( )
- b. Puts the health or safety of the participant at risk ~~by failing to perform job duties under the employment agreement.~~ (7-1-26)( )
- c. Does not receive and document the required ongoing training and requalification. (7-1-26)

05. **Limitations.** The SB ~~must:~~ (7-1-26)( )

- a. ~~Not~~ Cannot provide, or be employed by an agency that provides, CSW services to the same participant; ~~and~~ (7-1-26)( )
- ~~b.~~ Is limited to three thousand one hundred twenty (3,120) hours per twelve (12) months unless otherwise authorized by the Department; ( )
- ~~bc.~~ For SDACS, Are required to meet the conflict-of-interest standards; ~~and~~ (7-1-26)( )
- ~~c.~~ SBs are limited to reimbursement for three thousand one hundred twenty (3,120) hours per calendar year across all participants served unless otherwise authorized by the Department. (7-1-26)
- ~~d.~~ Is not reimbursed for missed appointments, attempted contacts, leaving messages, scheduling, transporting participants, or documenting services. ( )

06. **Time Sheets and Invoices.** SBs must submit accurate time sheets and invoices for reimbursement or be subject to recoupment. (7-1-26)

811. **~~SUPPORT BROKER (SB)~~ DUTIES AND RESPONSIBILITIES.**

01. **Initial Documentation.** Prior to beginning employment for the participant, the SB must type and complete and submit to the participant, the packet of information provided by the FEA. This packet must include documentation of: (7-1-26)

- a. SB application approval by the Department; (7-1-26)
- b. A completed background check, including clearance; and (7-1-26)
- c. A completed employment agreement in accordance with these rules. The negotiated rate must not exceed the maximum hourly rate for SB services established by the Department. (7-1-26)

**02. Documentation.** SB must complete ~~all required~~ documentation, ~~required by the Department~~ including ~~documentation of~~ the date, time in and out, and type of service provided and billed for. ~~All~~ Documentation for services will be retained by the SB for five (5) years. (7-1-26)(      )

**03. Required Duties.** SB services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the SB must: (7-1-26)

a. Assist in facilitating the person-centered planning process as directed by the participant and consistent with the HCBS rules; (7-1-26)

b. Develop a ~~written~~ typed SSP with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified ~~with the participant's wants and preferences~~, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. The SSP must be authorized by the Department; (7-1-26)(      )

c. Assist the participant to monitor and review their budget; (7-1-26)

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; (7-1-26)

e. Adhere to Department quality assurance measures; (7-1-26)

f. Assist the participant to complete the annual re-determination process as needed, including updating the SSP and submitting it to the Department for authorization; (7-1-26)

g. Assist the participant, as needed, to meet the participant responsibilities outlined in these rules and assist the participant, as needed, to protect their own health and safety; (7-1-26)

h. Complete the Department-approved background check waiver form when a participant chooses to waive the background check requirement for a CSW. Completion of this form requires that the SB provide education and counseling to the participant and their COS regarding the risks of waiving a background check and assist with detailing the rationale for waiving the background check and how health and safety will be protected; (7-1-26)

i. Assist children enrolled in the FDCS option as they transition to adult DD services; (7-1-26)

j. Sign the written SSP; (7-1-26)

k. Report concerns or discrepancies in documentation and services provided to the Department immediately. (7-1-26)

**04. Additional Duties.** In addition to the required SB duties, each SB must be able to provide the following services when requested by the participant: (7-1-26)

a. Assist the participant to develop and maintain a COS; (7-1-26)

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; (7-1-26)

c. Assist the participant to negotiate rates for paid CSW; (7-1-26)

- d. Maintain documentation of supports provided by each CSW and participant's satisfaction with these supports; (7-1-26)
- e. Assist the participant to monitor community supports; (7-1-26)
- f. Assist the participant to resolve employment-related problems; (7-1-26)
- g. Assist the participant to identify and develop community resources to meet specific needs; and (7-1-26)
- h. Assist the participant in distributing the SSP to CSWs or vendors. (7-1-26)

05. **Termination of Services.** If ~~an~~ SB decides to end services ~~with a participant~~, they must give the participant and the Department at least thirty (30) days' written notice prior to termination ~~of services~~. The SB must assist the participant ~~to~~ in identifying a new SB ~~and provide the participant and new SB with a written service transition plan by the date of termination. The transition plan must include an updated SSP that reflects current supports being received, details about the existing CSWs, and unmet needs. Participants can change SB at any time.~~ (7-1-26)(    )

812. – 814. (RESERVED)

815. **COMMUNITY SUPPORT WORKER (CSW) LIMITATIONS.**

A paid CSW ~~must~~ cannot be the spouse of the participant, or the parent or legal guardian if the participant is a minor child. CSWs cannot supplant the role of the parent or legal guardian, be paid to fulfill any of their legal obligations, or be paid to perform or assist the participant in meeting the participant's responsibilities. For FDACS, they must: 1) not be the parent or legal guardian of the participant; 2) CSWs must avoid any conflict of interest by not having direct control over the participant's choices; 3) avoid any conflict of interest; and 4) not or receive undue financial benefit from the participant's choices. (7-1-26)(    )

~~01. **Work Limit.** A CSW for SDACS cannot work more than twelve (12) hours in a day without authorization from the Department.~~ (7-1-26)

~~021. **SDACS.** SDACS CSWs cannot be younger than seventeen (17) years of age except when for sixteen (16) year olds providing chore services and then may be sixteen (16) years of age. CSWs cannot work more than twelve (12) hours a day without authorization from the Department.~~ (7-1-26)(    )

~~032. **FDACS.** A paid CSW may provide unskilled supervision, but cannot:~~ (7-1-26)

- ~~a. Supplant the role of the parent or legal guardian;~~ (7-1-26)
- ~~b. Be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child;~~ (7-1-26)
- ~~ea. Be under the age of sixteen (16) years old; or~~ (7-1-26)
- ~~db. Be under the age of eighteen (18) and Transport or be left alone with a the participant under the age of eighteen (18) years old.~~ (7-1-26)(    )

816. **PAID COMMUNITY SUPPORT WORKER (CSW) DUTIES AND RESPONSIBILITIES.**

01. **Initial Documentation.** Prior to providing goods or services to the participant, the CSW must type and complete the packet of information provided by the FEA and submit it to the FEA. When the CSW will be providing services, this packet must include documentation of: (7-1-26)(    )

- a. A completed background check, including clearance or documentation that this requirement has been waived by the participant in accordance with these rules. Individuals listed on a state or federal provider

exclusion list must not provide paid supports; (7-1-26)

b. A completed employment agreement with the participant in accordance with these rules. If the CSW is provided through an agency, the employment agreement must include the specific individual who will provide the support and the agency's responsibility for tax-related obligations; (7-1-26)

c. Current state licensure or certification if identified support requires certification or licensure; and (7-1-26)

d. A statement of qualifications to provide supports identified in the employment agreement. (7-1-26)

02. **Employment Agreement.** The CSW must deliver supports as defined in the employment agreement. (7-1-26)

03. ~~Documentation~~ **Time Sheets and Invoices.** The CSW must ~~track and document~~; ( )

a. Accurately record the time required to perform the identified supports ~~and accurately report the time on the time sheets provided by the participant's FEA, or complete an invoice that reflects the type of~~ with the support provided, the and date the support was provided, and the negotiated rate for the support provided, for submission to the participant's FEA. Failure ~~to do so~~ may result in recoupment. (7-1-26)( )

~~04b. Time Sheets and Invoices. The CSW must obtain the signature of the participant or their legal representative on~~ Sign each completed time sheet or invoice and obtain the signature of the participant or their legal representative prior to submitting the document submission to the FEA for payment. Time sheets or invoices that are not signed ~~by the CSW and the participant or their legal representative as required~~ will not be paid. Time sheets submitted and approved by the participant through the FEA electronic system meet these signature requirements. (7-1-26)( )

817. – 819. (RESERVED)

820. **SUPPORT AND SPENDING PLAN (SSP) DEVELOPMENT.**

01. **Requirements.** The participant, ~~with the help of~~ assisted by their SB, must develop a comprehensive SSP based on the information gathered during person-centered planning. ~~The person-centered planning process must that~~ meets all HCBS requirements. The SSP is not valid until authorized by the Department. The SSP must include: (7-1-26)( )

a. The participant's preferences and interests by identifying all ~~the~~ supports and services, ~~both paid and non-paid~~, the participant wants and needs to live successfully in their community. (7-1-26)( )

b. Paid or non-paid supports that focus on the participant's wants, needs, and goals in the following areas: (7-1-26)

i. Personal health and safety including quality of life preferences; (7-1-26)

~~ii. Securing and maintaining employment for SDCS;~~ (7-1-26)

iii. Establishing and maintaining relationships with family, friends, and others to build the participant's COS; (7-1-26)

iii. For SDCS: ( )

(1) Securing and maintaining employment; ( )

~~iv.~~ (2) Learning and practicing ways to recognize and minimize interfering behaviors for SDCS; and (7-1-26)( )

- ~~v.~~(3) Learning new or improving existing skills to accomplish set goals ~~for SDCS~~. (7-1-26)( )
- c. Support needs such as: (7-1-26)
- i. Medical care and medicine for SDCS; (7-1-26)
- ii. Skilled care including therapies or nursing needs for SDCS; (7-1-26)
- iii. Community involvement; (7-1-26)
- iv. Preferred living arrangements including possible roommate(s); and (7-1-26)
- v. Response to emergencies including access to emergency assistance and care. ( )
- d. ~~This plan should reflect the~~ wants, preferences, and needs of the whole person, regardless of payment source, if any. (7-1-26)( )
- de. Risks or safety concerns in relation to the identified support needs ~~on the participant's SSP~~. The plan must be active and specify the goods, supports or services needed to address the risks for each issue listed, with at least three (3) backup plans to implement for each identified risk ~~to implement in case the need arises~~; (7-1-26)( )
- ef. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; and (7-1-26)( )
- fg. The budgeted amounts planned in relation to the participant's needed supports. The FEA will compare and match the employment agreements to the appropriate support categories identified on the initial SSP prior to processing time sheets or invoices for payment; and. (7-1-26)( )
- 02. Limitations.** (7-1-26)
- a. Traditional Adult DD waiver services, rehabilitative services, or habilitative services ~~must~~ cannot be purchased under the CDCS option. ~~Because a participant cannot receive these traditional services and CDCS at the same time, the~~ participant, the SB, and the Department must all work together to ensure that there is no interruption of required services when moving between traditional services and the CDCS option; (7-1-26)( )
- b. ~~Traditional Adult DD waiver services, rehabilitative, or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and CDCS at the same time, the participant, the SB, and the Department must all work together to ensure that there is no interruption of required services when moving between traditional services and the CDCS option.~~ Paid community supports cannot be provided in a group setting with recipients of traditional Adult DD waiver services, rehabilitative, or habilitative services. This does not prevent a CDCS participant from choosing to live with recipients of these services; (7-1-26)( )
- c. All paid community supports must fit into a type of community support described in these rules. The SSP must not include supports or services that are illegal, that adversely affect the health and safety of the participant, ~~that do harm~~, or that violate or infringe on the rights of others; (7-1-26)( )
- d. SSPs that exceed the approved budget amount will not be authorized; and (7-1-26)
- e. Time sheets or invoices exceeding the authorized SSP amount will not be paid by the FEA. (7-1-26)

(BREAK IN CONTINUITY OF SECTIONS)

**829. QUALITY ASSURANCE.**

The Department will implement quality assurance processes to ensure: access to CDCS; participant direction of SSPs and services; participant choice and direction of providers; safe and effective environments; and participant satisfaction with services and outcomes. (7-1-26)

~~01. Adult Services Outcome Review (ASOR).~~ Each participant will have the opportunity to provide feedback to the Department about their satisfaction with consumer-directed services utilizing the ASOR. (7-1-26)

~~02. Adult Service Outcomes.~~ Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: (7-1-26)

~~a. Access to care; (7-1-26)~~

~~b. Choice and control; (7-1-26)~~

~~c. Respect and dignity; (7-1-26)~~

~~d. Community integration; and (7-1-26)~~

~~e. Inclusion. (7-1-26)~~

**031. CSWs and SBs Quality Assurance Activities.** CSWs and SBs must participate and comply with quality assurance activities identified by the Department including performance evaluations, satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records. (7-1-26)

**042. Participant Choice of Paid CSW.** Paid CSWs must be selected by the participant, or their chosen representative, and meet the qualifications identified in this rule. (7-1-26)

**053. Complaint Reporting and Tracking Process.** The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. (7-1-26)

**064. Quality Oversight Committee.** A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. (7-1-26)

**075. Quarterly Quality Assurance Reviews.** On a quarterly basis, the Department will perform an enhanced review of services for those participants who have waived the criminal history check requirement for a community support worker or who have their legal guardian providing paid services. These reviews will assess ongoing participant health and safety and compliance with the approved SSP. (7-1-26)

**086. HCBS Specific Reviews.** The Department will implement quality assurance and improvement activities to ensure compliance with HCBS rules. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**833. FISCAL EMPLOYER AGENT (FEA): CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS).**

**01. Federal Tax ID Requirement.** The FEA must obtain a separate Federal Employer Identification Number (FEIN) specifically to file tax forms and to make tax payments on behalf of program participants. In addition, the provider must: (7-1-26)

**a.** Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for

FEIN in the participant's file. (7-1-26)

b. Retire participant's FEIN when the participant is no longer an employer under CDCS. (7-1-26)

**02. Requirement to Report Irregular Activities or Practices.** The provider must report to the Department any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations. (7-1-26)

**03. Policies and Procedures.** The provider must maintain a current manual containing comprehensive policies and procedures. The provider must submit the manual and any updates to the Department for approval. (7-1-26)

**04. Key Contact Person.** The provider must provide a key contact person and at least (2) two other people for backup who are responsible for answering calls and responding to e-mails from Department staff and responding to the Department within one (1) business day. (7-1-26)( )

**05. Face-to-Face Transitional Participant Enrollment.** The provider must conduct face-to-face transitional participant enrollment sessions in group settings or with individual participants in their homes or other designated locations. The provider must work with the regional Department staff to coordinate and conduct enrollment sessions. The face-to-face encounter may occur via virtual care. (7-1-26)

**06. SFTP Site.** The provider must provide an SFTP site for the Department to access with the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. The site must be user name and password protected. The provider must have the site accessible to the Department upon commencement of the readiness review. (7-1-26)

**07. Required IRS Forms.** The provider must prepare, submit, and revoke the following IRS forms in accordance with IRS requirements and must maintain relevant documentation in each participant's file including: (7-1-26)

a. IRS Form 2678; (7-1-26)

b. IRS Approval Letter; (7-1-26)

c. IRS Form 2678 revocation process; (7-1-26)

d. Initial IRS Form 2848; and (7-1-26)

e. Renewal IRS Form 2848. (7-1-26)

**08. Requirement to Obtain and Revoke Power of Attorney.** The provider must obtain an Idaho State Tax Commission Power of Attorney (ID-POA) from each participant it represents, revoke the Form ID-POA when the provider no longer represents the participant, and maintain the relevant documentation in each participant's file. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**837. FISCAL EMPLOYER AGENT (FEA): PAYMENT PROCESS.**

**01. Process Payroll.** The provider must process payroll, including time sheets and taxes, in accordance with the participant's SSP. The payroll process must include: (7-1-26)

a. Payment of employer and withholding taxes to State Tax Commission and Internal Revenue Service. (7-1-26)

- b. Payment of invoices to vendors. (7-1-26)
- c. Management of participant budget funds as per authorized SSP. (7-1-26)
- d. Garnishment of wages as per court orders. (7-1-26)
- e. Preparation of year-end federal and state tax forms. (7-1-26)
- f. Payment of worker's compensation insurance premiums. (7-1-26)

**02. Requirement to Track and Log Time Sheet Billing Errors.** The provider must track and log time sheet billing errors or time sheets that cannot be paid due to late arrival, missing, or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the time sheets. (7-1-26)

**03. Requirement to Track and Log Improperly Cashed or Improperly Issued Checks.** The provider must track and log occurrences of improperly cashed or improperly issued checks and stop payment on checks when necessary. The provider must reissue lost, stolen, or improperly issued checks at no expense to the participant or the Department within fourteen (14) calendar days of when the error occurred. (7-1-26)

**04. Process Employee Payments.** The provider must verify documentation and process payments via the preference of employees. The employee payment process includes: (7-1-26)

- a. Receipt of time cards from employees via mail, fax, or website by specified due dates. (7-1-26)
  - b. Review time cards for accuracy and verify that time cards contain the following information: (7-1-26)( )
    - i. Employer name and ID number. (7-1-26)
    - ii. Employee name and ID number. (7-1-26)
    - iii. Hours of work. (7-1-26)
    - iv. Code for service. (7-1-26)
  - c. Match codes to employment agreement to verify rate of pay. (7-1-26)
  - d. Verify that rate of pay multiplied by the hours worked per each pay period is equal to the gross pay. (7-1-26)
  - e. Calculate all taxes and other withholding. (7-1-26)
  - f. Pay employees every two (2) weeks or semi-monthly. (7-1-26)
  - g. Contact participant and representative to resolve problems with time cards or other documents prior to pay-date, if possible. (7-1-26)( )
  - h. Maintain an electronic complaint log of payroll issues and resolutions. (7-1-26)
  - i. Verification of any money remaining in each participant's budget and specific service category prior to issuing payment. (7-1-26)
- 05. Process Vendor Payments.** When participants submit requests for payment to vendors, the provider must: (7-1-26)
- a. Review, and maintain on file, the vendor payment request with attached voided vendor receipt

- submitted by the participant. (7-1-26)
- b.** Ensure item or payment is authorized on the participant's SSP. (7-1-26)
  - c.** Issue payment to the vendor on the same schedule as payroll. (7-1-26)
- 06. Process Independent Contractor or Outside Agency Payments.** When the participant hires an independent contractor or outside agency, in accordance with the SSP, the provider must: (7-1-26)
- a.** Obtain a W-9 from the contractor or agency. (7-1-26)
  - b.** Review, and maintain on file, the independent contractor or agency agreement submitted by the participant. (7-1-26)
  - c.** Review, and maintain on file, the independent contractor or agency invoice for services submitted by the participant. (7-1-26)
  - d.** Ensure service or payment is authorized on the SSP. (7-1-26)
  - e.** Issue payment directly to the independent contractor or agency. (7-1-26)
- 07. End-of-Year Processing.** For purposes of end-of-year processing, the provider must maintain relevant documentation and must: (7-1-26)
- a.** Refund over-collected Federal Insurance Contributions Act tax (FICA) to applicable employees, or to state government; (7-1-26)
  - b.** Prepare, file, and distribute IRS Form W-2 for each employee; (7-1-26)
  - c.** Prepare and file IRS Form W-3 for each participant represented; (7-1-26)
  - d.** Prepare and file State Form 967 for state income taxes withheld for each employer; (7-1-26)
  - e.** Report and pay any Unclaimed Property per Idaho State Tax Commission rules; and (7-1-26)
  - f.** Report and pay all state and federal unemployment insurance premiums. (7-1-26)
- 08. Transition to New FEA.** The following items must be addressed if a participant transitions to a new FEA provider. For the purposes of a smooth transition between FEA providers, the two (2) providers must work closely with one (1) another to transfer the participant from the services one (1) is no longer providing to the services the other is providing. The following items must be transferred: (7-1-26)
- a.** Participant's FEIN and FEIN mailing address. (7-1-26)
  - b.** IRS Form 2678 Agent/Payer Authorization. (7-1-26)
  - c.** Depositing taxes and filing report. This includes Federal and State tax withholdings and Federal Unemployment Tax Act tax (FUTA). (7-1-26)
  - d.** Participant's FUTA Liability Status. (7-1-26)
  - e.** FICA and FUTA Exemption Status of Participant Employees. (7-1-26)
  - f.** Unemployment Insurance (U/I). (7-1-26)
  - g.** Unemployment Insurance Experience Rate and Taxable Wage Base. (7-1-26)

- h.** State Unemployment Insurance Liability Status of the Participant and Exempt Employees. (7-1-26)
- i.** Unemployment Insurance Filing and Depositing. (7-1-26)
- j.** State Income Tax - Account Number Agent Authorization, Filing and Depositing. (7-1-26)
- k.** Budget Authorization - Authorized Services Spent and Remaining, Authorized Providers, and Authorized Provider Rates. (7-1-26)
- l.** Participant's Representative, and Participant's Employee and Provider Demographic Information. (7-1-26)
- m.** Participant's Employee New Hire Reporting, Liens and Garnishments, and Tax and Other Information. (7-1-26)
- n.** Participant's Independent contract and other information. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**842. FISCAL EMPLOYER AGENT (FEA): PERFORMANCE METRICS.**

**01. Readiness Review.** Complete a readiness review conducted by the Department with the provider prior to providing FEA services. (7-1-26)

**a.** The Department will access SFTP site for review of provider documents and conduct ~~an~~ onsite reviews. (7-1-26) ( )

**02. Fiscal Support and Financial Consultation.** The provider must provide each participant with fiscal support and financial consultation. (7-1-26)

**03. Quarterly Reconciliation.** Each fiscal quarter after initiating service, the provider must reconcile its Medicaid Billing Report to a zero-dollar (\$0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's SSP balance to a zero dollar (\$0) balance with Medicaid's reimbursements. The provider must: (7-1-26)

**a.** Show one hundred percent (100%) compliance with the required quarterly reconciliation of the Medicaid Billing Report. (7-1-26)

**b.** Notify the Department immediately if an issue is identified that may result in the provider not reconciling the Medicaid Billing Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars (\$50) each week until the provider has reconciled with Medicaid to a zero dollar (\$0) balance. (7-1-26)

**04. Cash Management Plan.** Each provider's cash management plan must equal one point five (1.5) times the monthly payroll cycle amount and can be forms of liquid cash and lines of credit. For example, if a provider's current payroll minimum has averaged one hundred thousand dollars (\$100,000) per payroll cycle, the provider would be required to have one hundred fifty thousand dollars (\$150,000) in a cash management plan. The Department must be on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**970. MANAGED CARE FOR DUALS.**

Medicaid benefit plan, referred to collectively as the Medicare/Medicaid Coordinated Plan (MMCP), for dual-eligible participants to enroll in a managed care organization (MCO) offering Idaho Medicaid Plus (IMPlus) or MMCP health plans. (7-1-26)( )

**971. MANAGED CARE FOR DUALS: DEFINITIONS.**

**01. Dual Eligible.** Participants with enhanced plan benefits, except those from Breast and Cervical Cancer eligibility, who are also enrolled in both Medicare Parts A and B. (7-1-26)

**02. Evidence of Coverage.** Contract between an MCO and the participant detailing covered services. (7-1-26)

**03. Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP).** Health plan option that fully integrates Medicare and Medicaid benefits under a single MAO. (7-1-26)( )

**04. Idaho Medicaid Plus (IMPlus).** MMCP health plan option where most Medicaid covered services are provided by one MCO. (7-1-26)

**05. Medicare Advantage Organizations (MAOs).** MCO approved by CMS to offer Medicare Advantage Plans. (7-1-26)

**06. Medicare Advantage Plan.** Private health plans contracted with CMS to provide Medicare Parts A, B, and D benefits. (7-1-26)

**07. Medicare/Medicaid Coordinated Plan (MMCP).** MMCP health plan option integrating Medicare and Medicaid covered services under a FIDE-SNP provided by one MCO. (7-1-26)

**08. Passive Enrollment.** Process where the Department assigns a participant to an IMPlus plan unless the participant actively enrolls in MMCP or opts out of IMPlus. (7-1-26)

**(BREAK IN CONTINUITY OF SECTIONS)**

**973. MANAGED CARE FOR DUALS: ELIGIBILITY AND ENROLLMENT.**

Only dual eligible participants over age twenty-one (21) may enroll in IMPlus or MMCP plans. Enrollment requirements vary by county. (7-1-26)

**01. Exclusions.** Individuals receiving Adult DD 1915(c) waiver benefits are excluded from IMPlus enrollment. (7-1-26)

**02. Exemptions.** Tribal members and pregnant women are exempt from mandatory enrollment requirements but may voluntarily enroll in MMCP plan options when available in their county of residence and retain the right to disenroll at any time. (7-1-26)

**03. Voluntary Counties.** Participants residing in a county with at least one (1) participating MCO may voluntarily enroll ~~in MMCP under~~ with an MCO offering any available IMPlus or MMCP plan and may terminate from a plan at any time. Coverage continues until the end of the month of termination. Once disenrolled, MMIS reenrolls participants under fee-for-service Medicaid. (7-1-26)( )

**04. Mandatory Counties.** Participants without an exclusion and residing in a county with two (2) or more active MCOs must enroll in either an IMPlus or MMCP plan. The Department assigns participants who fail to choose a plan into an IMPlus MCO. (7-1-26)

**05. Passive Counties.** The Department enrolls participants without an exclusion and residing in a

county with only one (1) participating MCO into the MCO's IMPlus plan unless they enroll in the MCO's MMCP plan or opt out by contacting the Department. These participants may opt out of IMPlus at any time. (7-1-26)

**974. MANAGED CARE FOR DUALS: COVERAGE AND LIMITATIONS.**

**01. Coverage.** All ~~MMCP dual~~ plan options include Medicaid-only Basic and Enhanced Plan services provided by Medicaid providers that are not MAOs. Medicaid may cover additional services not included in the MCO's Evidence of Coverage. MAOs providing MMCP plans may limit or expand MAO-covered services, including Medicare Parts A, B, and D benefits or supplemental services unavailable on Medicaid or Medicare, as detailed in the contract and Evidence of Coverage. (7-1-26)( )

**02. Limitations.** Services not included in the Evidence of Coverage are carved out and provided under fee-for-service Medicaid or other contracted entities. (7-1-26)

**975. MANAGED CARE FOR DUALS: GOLD CARD.**

**01. Card Eligibility.** Providers enrolled with an MAO and MCO can receive a gold card, as described in Subsection 005.31. ( )

**975. – 979. (RESERVED)**

**(BREAK IN CONTINUITY OF SECTIONS)**

**985. LIENS AND ESTATE RECOVERY: LIMITATIONS AND EXCLUSIONS.**

**01. Limitations on Estate Claims.** Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. (7-1-26)

**02. Expenses Deducted From Estate.** The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim: (7-1-26)

**a.** Funeral expenses reasonably necessary for burial or cremation services approved on a case-by-case basis at the discretion of the Department. (7-1-26)

**b.** Administrative expenses of the estate may be deducted in accordance with Section 56-218, Idaho Code. (7-1-26)

**03. Interest on Claim.** The Department's claim does not bear interest ~~until the claim becomes recoverable. Interest on the claim accrues at the legal rate of interest~~ except as otherwise provided by statute or agreement. (7-1-26)( )

**04. Excluded Land.** Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. (7-1-26)

**05. Certain Life Estates.** The value of a life estate owned by a Medicaid participant, or their spouse will not be subject to estate recovery if: (7-1-26)

**a.** Neither the Medicaid participant or their spouse ever owned the remainder interest; or (7-1-26)

**b.** The life estate was created prior to July 1, 1995. (7-1-26)

**06. Marriage Settlement Agreement or Other Such Agreement.** A marriage settlement agreement or other such agreement that separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. (7-1-26)

**07. Undue Hardship Exception.** It is not considered undue hardship when family members anticipate or expect an inheritance or will be inconvenienced economically by the lack of an inheritance. (7-1-26)

**a.** An applicant for an undue hardship waiver must be family with a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. (7-1-26)

**b.** Undue hardship waivers will be considered in the following circumstances: (7-1-26)

**i.** The estate subject to recovery is income-producing property that provides the sole source of support for heirs; or (7-1-26)

**ii.** Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or (7-1-26)

**iii.** The Department's claim is less than five hundred dollars (\$500) or the total assets of the entire estate are less than five hundred dollars (\$500), excluding trust accounts or other bank accounts. (7-1-26)

**c.** Any claim may be waived or deferred by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to their death, or by their legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case-by-case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery. (7-1-26)

**08. Set Aside of Transfers.** Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether the asset transfer resulted, or could have resulted, in a period of ineligibility. (7-1-26)

**09. Release of Estate Claims.** The Department may enter into a written agreement with an authorized representative to release the Department's claim when the claim is paid within thirty-six (36) monthly payments or less. ( )